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Final Evaluation Report of Family PACT

Presented to the California
Department of Health Services,
Office of Family Planning

By the

Bixby Center for Reproductive
Health Research & Policy
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University of California, San Francisco

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Family PACT
Planning • Access • Care • Treatment

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Foreword

This evaluation report captures the tremendous leadership by the federal and state governments to marshal the resources, guidance, and monitoring to ensure that high-quality family planning services were delivered to millions of eligible, low-income women, men, and adolescents through Family PACT (Planning, Access, Care and Treatment).

In turn, the network of dedicated professionals working in both the public and private sectors who actively and professionally operate the program is reflected in these evaluation report findings. The University of California, San Francisco (UCSF), has worked with the California Department of Health Services, Office of Family Planning (DHS-OFP), to capture the spirit and essence of this endeavor. While clearly an evolving program in progress, many accomplishments can be highlighted.

Furthermore, the commitment to program improvement and quality of services is reflected in the overall efforts of DHS to continuously strengthen Family PACT. The complexity and ever-changing nature of the program, given its multiple settings, agencies, organizations, and tasks—above and beyond the many new contraceptive technologies and clinical practices—require that careful documentation be used for ongoing quality improvement.

It is in the spirit of this evaluation to note both strengths and limitations of Family PACT. Given the magnitude of the program, as well as the strengths and limitations inherent in any evaluation methodology, we have strived to present the data as the program unfolds. Following the results, we include a series of programmatic- and evaluation-related recommendations that reflect insights gained through the program support, monitoring, and evaluation activities of the UCSF team.

Section 1.1: *Executive Summary*

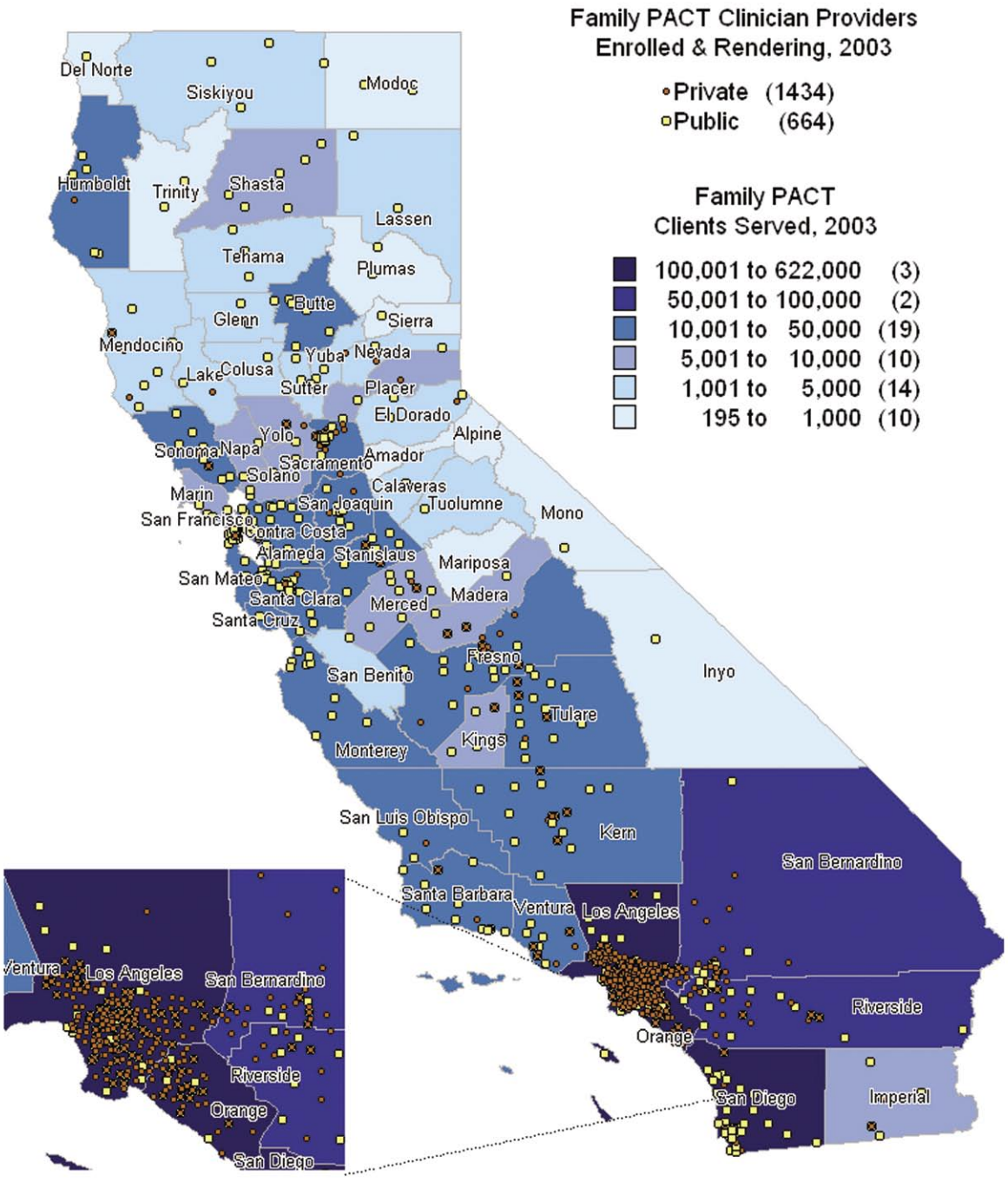
Background

In fiscal year (FY) 1996-97, the California State Legislature established the Family PACT (Planning, Access, Care and Treatment) Program to ensure that low-income women, men, and adolescents would have access to the health education, counseling, and clinical services they need to reduce unintended pregnancy and improve reproductive health. Family PACT provides clinical services for family planning and reproductive health at no cost to low-income residents, filling a critical gap in health care for the indigent, uninsured, and working poor. Family PACT serves Californians who are at risk of pregnancy or causing pregnancy, have a gross family income at or below 200 percent of the Federal Poverty Level (FPL), and have no other source of health care coverage for family planning services. The program is administered by the California Department of Health Services, Office of Family Planning (DHS-OFP).

With the 1999 receipt of federal funding through a Centers for Medicare & Medicaid Services (CMS) Research and Demonstration Waiver, Family PACT has been able to extend its reach substantially. By 2003, Family PACT's provider network included more than 2,000 enrolled providers from both the public and the private sector serving over 1.5 million women and men throughout 58 diverse counties (see figure 1.1.1). California's family planning waiver is the largest in the country and accounts for approximately 75 percent of all clients served by federal family planning waiver programs, and two-thirds of federal reimbursements for these programs. The waiver has enabled development of programs for provider recruitment and training, as well as client outreach and recruitment to expand access to family planning services for hard-to-reach populations. The goals of the waiver were to increase access to family planning services among adolescents, males, and women living in areas of high unmet need for family planning services. The Family PACT evaluation was shaped by these three goals, as well as other issues related to quality of care and utilization management that were deemed critical goals of the program.

Figure1.1.1

California: Number of Family PACT Providers in the State by Provider Type and Range in the Number of Clients Served in the 58 Counties (N=1.55 Million Clients Served), 2003.



Program Support and Evaluation

In 2000, the state contracted with the University of California, San Francisco (UCSF), to conduct a five-year evaluation of the Family PACT Program, including the Waiver Demonstration Project; this evaluation built on the UCSF monitoring of Family PACT that began when the program was implemented in 1997. The purpose of the evaluation was twofold: to provide on-going support for issues of program implementation and to assess the impact of the program on fertility and other health outcomes. The following complementary data sources and techniques was used to answer the evaluation questions:

- **Family PACT Program Standards and Guidelines**
- **Administrative data**
- **Client exit interviews**
- **Focus groups with clients and key stakeholders**
- **Medical records**
- **Provider surveys**
- **National, state, and county birth data**
- **Surveys of representatives from community-based organizations, including the state Teen Pregnancy Prevention (TPP) programs**
- **Cost-benefit analyses**
- **Telephone access surveys**
- **TeenSMART Outreach (TSO) Evaluation**

This final evaluation report presents the results of UCSF's research and monitoring activities of the Family PACT Program for the time periods beginning in the pre-waiver year FY 1997-98 and the waiver baseline year 1999 through the implementation years 2000-2003. Unless otherwise noted, years referred to in this report are calendar years.

1 For the original CMS Waiver Demonstration Project, 14 counties were identified as geographic areas of high unmet need. Identification of target counties was based on high levels of unmet need and shortages of available providers and include Alpine, Fresno, Imperial, Mariposa, Orange, Placer, Riverside, Sacramento, San Bernardino, Sierra, Solano, Ventura, Yolo, and Yuba counties. These counties range from the very rural and sparsely populated to more densely populated urban counties.

Overview of Results

CLIENTS

Family PACT dramatically expanded access to care for low-income Californians in need of publicly-funded family planning services, serving more than 1.5 million clients in 2003.

- The number of clients served by Family PACT more than doubled during the five-year evaluation period, from 750,000 in FY 1997-98 to 1.55 million in 2003.
- During the same period, the number of adolescent female clients increased by 87 percent, the number of male clients by 566 percent, and the number of clients in the 14 targeted counties of high unmet need by 142 percent.[1]
- The ethnic and racial diversity of the client population demonstrates the program's success in providing culturally and linguistically competent services by reaching ethnic and racial groups that are often marginalized. Two-thirds of the clients served in 2003 were Latino, and while Asian, Filipino, and Pacific Islanders represented only six percent of the Family PACT client population in 2003, their numbers had increased 166 percent since FY 1997-98.

Outreach to eligible populations increased awareness of Family PACT and use of Family PACT services.

- The UCSF evaluation of the TPP Media Campaign demonstrated that the campaign was effective in garnering name recognition of the Family PACT Program while raising the public's awareness of teen pregnancy prevention issues. There was evidence that the media campaign increased the number of new clients by an additional 25,000 to 55,000 during the year following its implementation in July 2001.
- Through the TSO Program, 21 providers had agency contracts to provide outreach in their communities since January 2004. TSO activities included establishing referral networks, providing information about clinic services to adolescents in formal group presentations, and conducting small group and one-on-one education and counseling sessions. During the first half of FY 2004-05, TSO staff reached nearly 17,000 youth through 800 group presentations and nearly 19,000 youth through one-on-one outreach activities. Additionally, TSO staff trained 223 youth to become peer educators or outreach workers.

Interviews with clients following their Family PACT visits indicated that the program has been very well-received by users of services.

- Most clients were satisfied with their Family PACT provider (98 percent) and with the birth control choices available to them (89 percent), would recommend the provider to their family and friends (98 percent), and were likely to return to the provider in the future (89 percent).

- Almost all clients were satisfied with their privacy when speaking to the clinician (99 percent) and with clinic staff (91 percent), and more than three-quarters of clients (78 percent) felt comfortable in the waiting room.

PROVIDERS

By 2003, more than 2,000 providers were participating in the Family PACT Program. Efforts to disenroll non-compliant Family PACT providers resulted in estimated annual savings of $6 to $18 million.

- The number of Family PACT providers delivering services to clients increased by 45 percent since the baseline year, from 1,451 in FY 1997-98 to 2,098 in 2003. The number of providers serving adolescent clients grew 50 percent, and providers serving male clients more than doubled. Since 1999, the number of private providers has been more than double that of public providers.

- Eighty-five Family PACT providers were disenrolled from the program due to non-compliance with program regulations. Cumulative savings attributed to disenrollment from program inception through FY 2003-04 were more than $65 million.

Collaborative partnerships with community-based organizations (CBOs), including the state's TPP programs, increased awareness of Family PACT and referrals to the program.

- More than 60 percent of organizations serving low-income populations in California have heard of Family PACT. Among these almost all (99 percent) knew of at least one Family PACT provider in their community to whom they could refer clients.

- DHS-OFP's requirement in FY 2003-04 that some TPP programs link their participants to Family PACT services was associated with stronger collaborative partnerships and a greater number of referrals.

- Nearly all (94 percent) TPP programs provided information about clinical family planning services to their teen participants, and 87 percent referred teen participants to family planning providers using formal referral mechanisms.

- Some TPP programs reported specific challenges that negatively affected their ability to build partnerships with Family PACT providers and refer adolescent participants to them. These programs reported difficulty finding interested Family PACT providers with whom to partner (20 percent), a desire for more guidance from OFP on how to facilitate linkages (21 percent), and a lack of resources about developing linkages (35 percent).

Most Family PACT providers offered some primary care services in addition to program benefits, or referred their clients for such services. Most providers also screened clients for public insurance eligibility.

- While primary care services were not covered under Family PACT, most providers offered such services on-site or referred clients to primary care. Most providers who gave referrals documented the referral in patient charts, appropriately passed on records to outside medical providers, gave the client directions, completed a referral form, and followed up with clients. Barriers to referrals included difficulty finding providers to serve uninsured patients, client resistance, and lack of resources to facilitate referrals.

- Most providers screened their clients for public insurance eligibility. Barriers to enrolling clients in public insurance programs included client reluctance to disclose insurance status and providers' unfamiliarity with these programs.

SERVICE UTILIZATION

Since program inception, the use of most Family PACT services increased, resulting in a substantial reduction in the number of cases of pelvic inflammatory disease (PID), chlamydia trachomatis (CT), and cervical cancer.

- In 2003, three-fourths (73 percent) of female clients were dispensed contraceptives through the Family PACT Program, a proportion that has been relatively stable over time. In contrast, the provision of barrier methods and vasectomies to male clients has declined steadily (from 74 percent in 1999 to 58 percent in 2003), suggesting an increase in males seeking other program services such as sexually transmitted infection (STI) testing, and education and counseling.

- Between 1999 and 2003, pregnancy testing declined from 18 percent of female clients to 13 percent in 2003. Among private providers, four percent of female clients received pregnancy tests in 1999, increasing slightly to five percent in 2003.

- From FY 1997-98 through 2002, education and counseling, laboratory services for most STIs, and most method-related laboratory tests increased, followed by a decline in 2003.

- STI test volume more than quadrupled from more than 716,000 tests in FY 1997-98 to 2.9 million tests in 2003. This increase was commensurate with the increase in clients served in the program each year. The proportion of female clients tested for any STI increased from 49 percent in FY 1997-98 to more than 61 percent in 2003; similarly, the proportion of male clients tested for any STI increased from more than 33 percent in 1999 to 70 percent in 2003. Through the provision of STI testing and treatment services to males, it is estimated that in FY 2001-02, Family PACT prevented approximately 5,800-6,000 cases of PID and contributed to an estimated 8,000-9,000 fewer cases of CT.

- In 2003, more than half of female clients received a Pap smear through Family PACT, with the highest proportion occurring among Latina women. In the cost-benefit analyses, it is estimated that annual cervical cancer screening by Family PACT resulted in more than 9,000 fewer lifetime cases of cancer among 618,261 women screened in the program. The largest number of averted cases occurred in women younger than 30.

- Family PACT reimbursements for client services grew from $219 million in 1999 to $414 million in 2003. The pace of increase, however, dropped considerably towards the end of the period, from a year-over-year increase of 26 percent from 1999 to 2000 to a 2 percent increase from 2002 to 2003. Payments for drug and supply services, which rose each year, made up the largest percentage of reimbursements, with contraceptives accounting for almost one-third of all program reimbursements. As a result of a decline in the number of private sector providers, expenditures for this group dropped in 2003, whereas public sector provider reimbursements continued to increase.

ADHERENCE TO PROGRAM STANDARDS

Consistent, high-quality care has been assured by requiring participating providers to adhere to the Family PACT Program Standards.

- All providers were expected to adhere to the seven Family PACT Standards covering the areas of: informed consent, confidentiality, availability of services, linguistic and cultural competence, access to care, clinical and preventive services, and education and counseling services. Evaluation data demonstrate that the majority of providers were compliant with informed consent requirements and offered services in the clients' preferred language. In addition clients were satisfied with the confidentiality and privacy of services provided under the program.

- Most Family PACT providers adhered to STI standards of care, including conducting sexual risk assessments, screening for CT and gonorrhea (GC), ensuring CT treatment, and documenting partner management.

- However, providers may have overscreened older women for CT and younger women for GC, and underreported CT cases to local public health departments.

PROGRAM OUTCOMES

Family PACT exceeded the waiver goal to reduce state fertility rates among adolescents and women living in counties with high unmet need for family planning services.

- Family PACT exceeded the waiver goal to reduce adolescent pregnancies by an average of two percent or more than projected in 1996. There were 85,500 fewer births than projected since the beginning of the waiver, despite a ten percent increase in the number of adolescent females. Statewide, actual adolescent fertility rates were 35.8 percent lower than projected for 2003.

- The number of births to women aged 15-44 was lower than projected both statewide and in the 14 targeted counties, exceeding the goals of the waiver. In 2003, the fertility rate was 7.3 percent lower than projected statewide and 4.6 percent lower than projected for the 14 targeted counties with high unmet need.

Family PACT made substantial progress in meeting the need for publicly-funded family planning services among adult and adolescent women.

- The proportion of women whose need for publicly-funded family planning services was met by Family PACT increased from 41 percent in 1999 to more than 57 percent in 2003. The proportion of need met by Family PACT increased from 30 to 37 percent among adolescent females aged 13-19 and from 46 percent to 68 percent among adult women aged 20-44.

Multi-disciplinary quality improvement efforts supported providers in meeting Family PACT standards of care.

- An array of quality improvement strategies supported providers in meeting Family PACT standards of care. Committees of providers, researchers, and trainers met regularly to review the scope of available services, identify quality improvement and utilization management issues, and make recommendations for provider education, performance, and training interventions.

- Quality improvement efforts brought attention to issues such as monitoring CT screening rates, supporting the collection of clients' Social Security numbers (SSNs), and encouraging the use of self-assessment guides to improve the quality of services.

Family PACT averted more than 200,000 unintended pregnancies annually.

- One year of Family PACT services providing access to effective methods of contraception averted an estimated 213,000 unintended pregnancies in the state; 205,000 pregnancies to female clients (including more than 43,000 pregnancies to adolescent female clients) and 8,000 to male clients.

- Had the 205,000 pregnancies to female clients occurred, they would have resulted in 94,000 live births, 79,000 abortions, 2,000 ectopic pregnancies, and 30,000 miscarriages.

Family PACT has been cost-effective and has resulted in total cost-savings of billions of dollars each year.

- The total expenditures for Family PACT clinical services in 2002 were $403.8 million. However, the cost of Family PACT was small relative to the dividends that California and the nation reap by preventing unintended pregnancies and STIs. Each pregnancy averted by Family PACT in 2002 saved the public sector more than $5,000 in medical, welfare, and other social service costs for a mother and child up to two years after birth, and more than $10,000 up to five years after birth.

- In total, Family PACT saved $2 billion in public expenditures that would have been spent on medical care, income support, and social services for the mother and child born as a result of an unintended pregnancy up to five years after birth.

- Every dollar spent on Family PACT client services saved an estimated $5.33 in medical and social service costs that would have resulted from an unintended pregnancy up to five years after birth.

- In addition, Family PACT saved $7.1 to $10 million in medical costs through its provision of CT testing and treatment services to males, increasing the program's cost-effectiveness.

NEXT STEPS

There is a need to continue to expand access to care among the state's low-income residents through increased provider enrollment, quality improvement and utilization efforts, improved client and provider outreach strategies, and collaborative relationships.

- The Family PACT Program should continue to expand the enrollment of clients with specific focus on vulnerable populations by developing new and improved outreach strategies and strengthening linkages with other programs.

- Special attention should be given to increase the number and geographic distribution of providers rendering Family PACT services.

- Quality improvement and utilization efforts and provider performance should be strengthened and monitored on an ongoing basis.

Conclusion

UCSF researchers used a mixed method evaluation approach to demonstrate that the Family PACT Program significantly expanded access to family planning services for California's low-income population, particularly adolescents, women living in areas of high unmet need, and men. The program also resulted in significant cost savings through the prevention of unintended pregnancies.

In the coming years, evaluation needs will change as Family PACT matures beyond a program concentrated on the expanding its provider network and increasing client utilization. Family PACT can develop into a program that has an increased focus on program integrity and quality, and on linkages of health and social service programs, particularly referrals of family planning clients to primary care services. Future evaluation will assess new waiver goals and requirements, as well as the program's dedication to increasing access to services, improving service delivery that meets standards of clinical care, and cost-effectiveness. With the availability of longitudinal and comparative data as the program continues, evaluation approaches will generate even greater robustness.

Efforts that continue to expand upon outreach, education, and quality improvement are necessary to maintain the success of the Family PACT Program. Access to family planning services for men, women, and adolescents living in remote and underserved areas remains essential, and new and innovative strategies are required to reach California's growing and changing population. Assuring the continuation of the program's high-quality, comprehensive family planning service delivery to the state's low-income communities is a critically important investment for the future of California, and, by example, the nation.

Section 1.2: *Family PACT Program Evaluation Overview*

In 1997, the DHS-OFP contracted with the UCSF to conduct ongoing monitoring and evaluation of Family PACT. In fiscal FY 1999-2000, DHS-OFP awarded an additional five-year contract for evaluation of the Family PACT Waiver Demonstration Project, as required by the CMS,[2] to UCSF. The purposes of the evaluation were: first, to provide on-going program support over the entire five-year demonstration period; and second, to assess the impact of the program on fertility, health, and fiscal outcomes. This final evaluation report describes the impact of the program from 1999 through 2003 on its desired outcomes.[3] The report begins with an overview of the Family PACT Program and a description of UCSF's study design and role in the evaluation, followed by detailed findings of the program's progress in achieving its goals and objectives. The report ends with programmatic recommendations generated by the evaluation, some of which DHS-OFP has already begun working to implement.

Background

California has a long history of providing family planning services to low-income residents. Between 1974 and 1997, DHS-OFP provided services through a limited number of family planning agencies. In an effort to increase access to these services, the California State Legislature established the Family PACT Program in FY 1996-97. This new program increased the number and types of providers eligible to participate and changed the reimbursement to providers from a contractual arrangement to a fee-for-service system. The Family PACT Program serves male and female California residents who are at risk of pregnancy or causing pregnancy, have a gross family income at or below 200 percent of the FPL, and have no other source of health care coverage for family planning services. The program aims to fill the gap between need and access to care for women and men who do not qualify for the full scope of services available under the Medi-Cal Program. Medi-Cal is generally restricted to applicants with children and a family income of significantly less than 100 percent of the FPL.[4] Children and adolescents are frequently able to qualify for Medi-Cal when their parents cannot. Additionally, Family PACT works in concert with state TPP programs and CBOs to achieve the following key objectives:

1. **To increase access to publicly-funded family planning services for low-income California residents**
2. **To increase the use of effective contraceptive methods by clients**
3. **To promote improved reproductive health**
4. **To reduce the rate, overall number, and public costs of unintended pregnancies**

Although Family PACT began as a state-funded program, in December 1999 CMS granted California a five-year Medicaid Section 1115 Research and Demonstration Waiver, providing federal funds for approximately 72 percent of the family planning services provided by the program. The remaining costs were borne by California. To satisfy the goals of the waiver, the program was expanded to provide STI testing services to males, granting men access to the same range of services as women except for female-specific contraceptive methods. The waiver enabled the development of innovative outreach and recruitment programs to expand access to family planning services for hard-to-reach populations. These included new and expanded efforts in the areas of provider recruitment, provider training, and client outreach. The three goals specifically set in the Family PACT Waiver Demonstration Project are as follows:

Goal 1: Reduce the number of pregnancies to low-income adolescent women (aged 15-19).

Goal 2: Reduce the number of unintended pregnancies among low-income women in geographic areas of high unmet need for family planning services.

Goal 3: Increase the number of low-income males receiving family planning services.

2 Formerly the Health Care Financing Administration.
3 Some data are provided for FY 1997-98 (the first year of Family PACT) and where available, for 2004.
4 Some Medi-Cal programs — for example pregnancy-related services — have higher income thresholds.

In May 2004, the Office of Family Planning submitted an application to CMS, requesting a three year waiver renewal of the Family PACT Medicaid Demonstration Project. Simultaneously, management of the DHS-OFP was transferred under the purview of the Maternal, Child and Adolescent Health (MCAH) Branch and the two entities officially merged in May 2005. Negotiations between DHS-OFP and CMS on the terms and conditions of the waiver renewal application have been ongoing and the original Family PACT Waiver Demonstration Project – slated to end on December 31, 2004, has been extended through December 31, 2005 as negotiations continue.

UCSF's Program Support and Evaluation

Since the inception of Family PACT, UCSF has provided two important functions to DHS-OFP: program support and evaluation. UCSF provided ongoing program support to Family PACT in the areas of quality improvement/utilization management, program communications, operational issues, and waiver reporting assistance. The focus of UCSF data-driven evaluation activities has been to assess the impact of program services on fertility and reproductive health outcomes in the three targeted populations and among all clients.

The UCSF Evaluation Team has comprised physicians, nurses, statisticians, demographers, social scientists, program analysts, medical anthropologists, and researchers trained in public policy, public health, and health economics. In its evaluation of Family PACT, UCSF has employed the highest standard of qualitative and quantitative research methods. These attributes have enabled the development of data and work products appropriately targeted to DHS-OFP, Family PACT providers, stakeholders, legislators, academic researchers, and lay audiences.

UCSF responsibilities in Family PACT have been governed by goals and objectives defined in the Scope of Work (SOW) established with DHS-OFP. All methods of implementing SOW activities have been developed in concert with DHS-OFP staff oversight.

Data Sources

The evaluation has employed a variety of complementary data collection sources and methodologies that have been used to ascertain process, outcome, and impact indicators. While each source has had some inherent limitations, when combined they have supplied more reliable information on which to base monitoring and evaluation findings than when used individually. In addition to using secondary data to monitor Family PACT, UCSF evaluation activities have generated substantial quantitative and qualitative data that inform program policy improvements, identify issues for further study, and enable monitoring of the effectiveness of interventions. Data sources used in this report are briefly described below:

- The Family PACT **client and provider file, enrollment forms, and claims data** have provided extensive information on the Family PACT provider and client populations and service utilization.

- The Family PACT **Program Standards and provider communications** (bulletins, clinical practice alerts, newsletters, and program letters) have been used to assess the extent to which providers are meeting expected performance, service delivery, and quality improvement parameters.

- **Client interviews** and **medical records reviews** have assessed client satisfaction and experiences with care, and providers' adherence to program standards, service delivery, and quality improvement indicators.

- **Surveys and focus groups with clients** and **key informants** have examined client barriers to care and experiences with the Family PACT Program.

- **Surveys and focus groups with CBOs and TPPs** have examined the extent to which outreach activities have been coordinated with other programs, as well as other programs' referrals to and awareness of Family PACT.

- **The Telephone Access Survey (TAS)** used **"mystery callers"** to assess barriers to care experienced by clients who called the program's automated information and referral service.

- A **survey of Family PACT providers** has examined the extent to which providers have offered primary care services or have referred family planning clients to outside agencies for primary care, and has identified obstacles and strategies for facilitating referrals.

- A **cost-benefit analysis** has measured the numbers of pregnancies averted and estimated the public sector medical, welfare and social costs that would have been incurred had these pregnancies not been averted. A **cost-effectiveness analysis** has assessed the expansion of diagnostic CT testing and treatment services to males and the reduction of CT-related morbidity.

- National, state, and local **birth statistics** and **population data** have estimated the program's impact on fertility rates.

- Several **state and nationwide health and reproductive health surveys** have provided estimates on the number of women at risk of unintended pregnancy and the number in need of publicly-funded family planning services.

Research produced with these methods and resources has been delivered primarily to DHS-OFP as work products, and secondarily as educational materials for a broader audience. Work products included periodic, ad hoc, and special studies reports, and educational materials such as fact sheets for lay and professional audiences. These deliverables are described in Appendix I.

UCSF has also produced numerous presentations for stakeholders upon request of DHS-OFP, on topics pertaining to Family PACT and to more general reproductive health issues. The Evaluation Team also created the TSO Handbook for use by TSO agencies. A list of UCSF papers and presentations on Family PACT appears in Appendix II. This work has provided a foundation for further UCSF contributions to the research knowledge base that are planned for later program years.

Section 1.3: *Comparison of Family PACT to Other Federal Family Planning Waiver Programs*

Key Findings:

- Twenty-one states had family planning waivers in 2005; some provided services only to postpartum women, while others offered comprehensive family planning and reproductive health benefits to men, women, and adolescents.

- California's family planning waiver program has been the largest in the country, targeting adolescents, males, and women living in counties with high unmet need for comprehensive family planning services. In addition, it has also allowed clients to enroll at the point of service. Although California's waiver has not paid for services provided to undocumented residents, these clients have received family planning through Family PACT at the state's expense.

- In 2001, California's Family PACT Program accounted for approximately 75 percent of all clients served by federal family planning waiver programs, and two-thirds of federal reimbursements for these programs.

Background

Since 1972, no-cost family planning services have been required benefits for all Medicaid enrollees in all states.[5] Individual states may define the scope of services they offer; there is no federal package of family planning benefits that applies to every state. Federal funds pay 90 percent of approved family planning services,[6] with remaining costs covered by the state. As of 2003, among women of reproductive age (15-44 years) living below the FPL in the United States (U.S.), 37 percent were insured by Medicaid.

Because Medicaid serves clients only at especially low income levels – in California, an enrollee's family income cannot exceed 100 percent of the FPL – access to family planning services for people who are poor yet have incomes slightly above the FPL is limited. In response to this issue, since the mid-1990s, states have been able to apply to CMS, Medicaid's administrative agency, to expand eligibility for family planning services to low-income people above the 100 percent FPL threshold via "waiver" research and demonstration programs.

These waiver programs provide only family planning care and were established for five-year demonstration periods, with renewals possible. Additional program requirements include maintaining budget neutrality, and, since 2001, establishing primary care referral processes for clients. States are free to set their own income requirements (generally 133-200 percent of the FPL) and other eligibility criteria such as age and gender restrictions. Provided services are governed by the terms and conditions negotiated between CMS and each state upon waiver approval. The information that follows describes fundamental differences among the programs and the unique characteristics of California's waiver.

Current Family Planning Waiver Programs

As of July 2005, 18 states had implemented waiver programs, and another three states had received CMS approval for their waivers but had not yet begun to serve clients. Thirteen programs (AL, AR, CA, MN, MS, NM, NY, NC, OK, OR, SC, WA, and WI) based eligibility on income only. In six states (AZ, FL, MD, MO, RI, and VA), eligibility has been extended only for existing Medicaid postpartum care, providing an additional one to five years of coverage. In two states (DE and IL), the loss of Medicaid coverage for any reason has rendered a client eligible for program participation.[i] Seven states' waiver programs (CA, MN, NY, NC, OK, OR, and WA) have provided services to both men and women (services in the other 14 waiver programs have been limited to women), and five states (AL, IL, NM, NC, and OK) have restricted services to clients aged 18 and older.[ii]

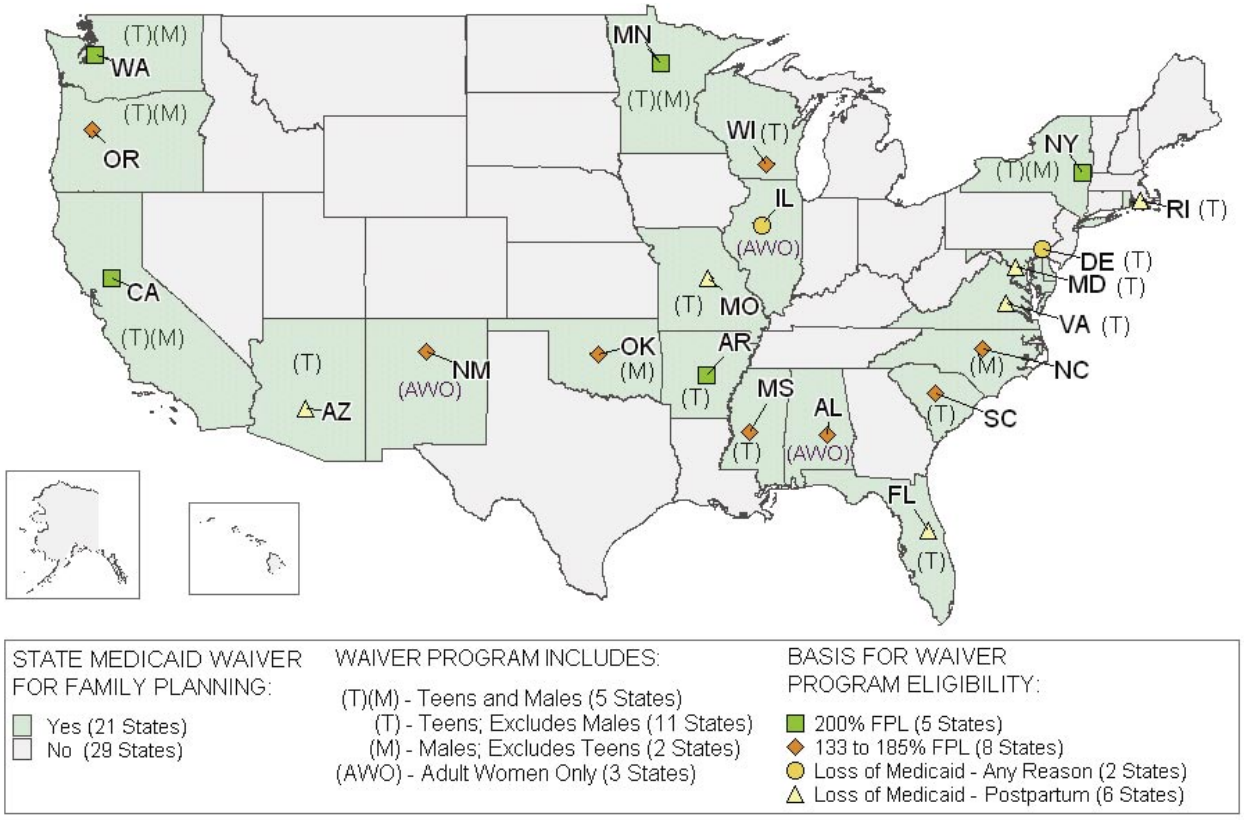
5 Cost-sharing for Medicaid Managed Care enrollees has been reported, though official Medicaid policy prohibits charging clients for family planning services.

6 Some services are reimbursed at a 50 percent rate, such as colposcopy services for cervical dysplasia, and follow-up care for a diagnosed reproductive health issue (e.g., STI treatment).

Eligibility criteria and available services have largely been defined by waiver populations of interest to individual states. In states that have granted eligibility only to postpartum women, for instance, each client necessarily has already given birth to at least one child, and those programs have therefore emphasized birth spacing and birth limiting (choosing when to stop having children) services for females.

In other states with broader eligibility criteria, potential clients may or may not already have children, and family planning have involved birth starting behaviors (choosing when to start having children), outreach to adolescents, and promoting male responsibility. The CMS State Medicaid Manual leaves these decisions up to the states.[7iii] (See figure 1.3.1)

Figure 1.3.1:
State Medicaid Waivers to Cover Family Planning Services



Note: All states are required to fund pregnancy-related care, including family planning services, for 60 days postpartum to women with incomes up to at least 133 percent of the FPL. States must obtain waivers to continue Medicaid coverage of family planning services for women who would otherwise lose Medicaid coverage postpartum. Source: "Medicaid: A Critical Source of Support for Family Planning in the U.S.," Alan Guttmacher Institute, April 2005. Map Created by UCSF.

7 Centers for Medicare & Medicaid Services. "Requirements and Limits Applicable to Specific Services." State Medicaid Manual-Part 4. Web page. http://www.cms.hhs.gov/manuals/45_smm/sm_04_4_4270_to_4390.1.asp#_toc490372893 (July 12, 2005).

Unique Attributes of Family PACT

California's Family PACT Program has been income-based (clients with family incomes at or below 200 percent of the FPL are eligible), has provided services to males and females, and has served adolescent and adult clients who are capable of becoming pregnant or causing a pregnancy. Women living in counties of high unmet need (as defined by DHS-OFP) have been another target population served by the program.

In addition to reaching these target populations, Family PACT has been notable for its sheer size, given the overall population of low-income individuals living in California: in 2004, 34.3 percent of women aged 10-55 and 30.4 percent of men aged 10-60 were living at or below 200 percent of the FPL.[iv] As of 2001, 12 of the 13 states with family planning waivers at the time served a total of 1.7 million clients; California's share was 1.3 million, or more than 75 percent. Expenditures for waiver program services among seven states responding to a recent survey were also concentrated in California; two-thirds of federal reimbursements among these states were made to Family PACT.[v]

Family PACT has been the only family planning waiver program providing services to undocumented residents. Reimbursements have been paid only with state funds. Income and other eligibility information have been based on self-report. This policy may change in response to future CMS mandates, and preliminary research has been conducted to assess the impact of such a change. Another unique feature of the program has been its on-site enrollment, allowing a client to enroll and receive services on the same day at the point of service.

While Family PACT providers have been required to request a SSN from each enrollee, clients have not had to give a SSN to receive services. Keeping program enrollment and service utilization as unrestricted as possible will enable continued progress in California family planning efforts. Policies may become more restrictive in the future because of federal concerns about eligibility, although self-reported information (including SSNs) has also been a component of the Oregon and Arkansas family planning waivers. Family PACT's demonstrated cost-effectiveness, combined with eligibility criteria that allow a high proportion of people in need to enroll, has represented an important state investment in preventing unintended pregnancy and improving reproductive health (see Section 5.7).

Summary

Federal family planning waivers have allowed nearly two million low-income men and women in 21 states to receive essential reproductive health services. These programs vary in eligibility criteria and family planning benefits. California's family planning waiver program is both the largest and most innovative, given its onsite enrollment capabilities and broad eligibility standards. In future waiver years, potential eligibility verification systems may present barriers to the use of Family PACT, limiting the ability of potential clients to access services. Such systems will be costly on both a per-client basis and with respect to providing services to low-income California residents in need of family planning services.

Section 2.1: *Clients Served*

Key Findings:

- From program inception through 2003, the Family PACT client population doubled from approximately 750,000 to more than 1.5 million clients served; an increase of 106 percent.
- Adolescents have accounted for approximately 20 percent of all clients. The number of adolescents participating in the program doubled between 1997 and 2003, from approximately 150,000 to 300,000 clients.
- The rate of growth in male clients has been much faster than that of female clients. Males accounted for approximately 12 percent of all clients in 2003; an increase from four percent at program inception.
- Clients served in the 14 target counties designated as being geographic areas of high unmet need increased 74 percent between 1999 and 2003, from 218,000 to 380,000.
- The racial and ethnic composition of the Family PACT client population changed little between 1999 and 2003, with the exception of the Asian, Filipino, and Pacific Islander population. In 2003, this population accounted for six percent of all clients; up from four percent in 1999.

Overall Demographic Trends

The growth in the number of clients served reflects the success of the Family PACT Program in expanding access to family planning services. Family PACT claims data, which is used to monitor trends in client enrollment, shows that between FY 1997-98 and 2003, the client population doubled, from approximately 750,000 to more than 1.5 million; an increase of 106 percent. Between 1999 and 2003, the client population grew 42 percent. Annual growth in clients served between 2000 and 2002 was approximately 12 percent. A slower growth rate of two percent occurred in 2003, which was attributed to the disenrollment of some private providers in 2002 and 2003, as well as slower growth in new providers entering the program.[8] The effect of these disenrolled private providers was primarily on clients served in southern California, mainly Los Angeles, and such disenrollment disproportionately affected growth in Latino male clients. Higher growth rates in clients served were seen among public providers and most other counties in the central and northern regions of the state.

In 2003, 76 percent of Family PACT clients were served in 10 counties (see Figure 2.1.1). In particular, many overall program trends and demographic profiles of clients were driven by Los Angeles County, which accounted for 40 to 43 percent of all clients served by the program between 1999 and 2003.

Figure 2.1.1:
Top Ten Counties as Proportions of All Family PACT Clients Served, 2003

Family PACT Total	1,550,277	100%
Rank / County	**No.**	**Pct.**
1 Los Angeles	621,884	40%
2 San Diego	122,283	8%
3 Orange	115,279	7%
4 San Bernardino	71,288	5%
5 Riverside	58,190	4%
6 Santa Clara	47,659	3%
7 Fresno	39,397	3%
8 Alameda	37,528	2%
9 Sacramento	35,927	2%
10 Ventura	28,702	2%
Top Ten Subtotal	1,178,137	76%

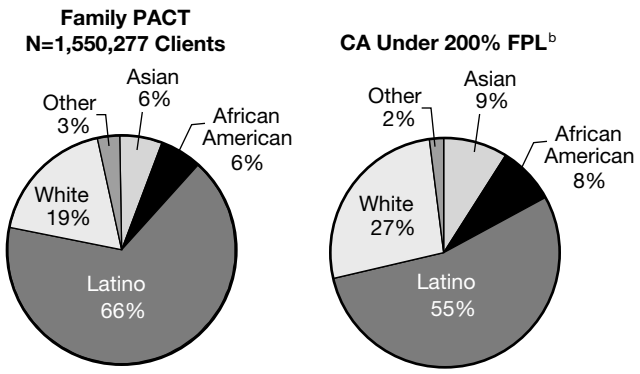
Source: Family PACT claims data

Race/Ethnicity

The demographic profile of Family PACT clients varied considerably from the overall California population at or below 200 percent of the FPL. The most notable variation was the proportion of Latino clients in the program (see Figure 2.1.2). This variation was largely due to the high concentration of clients (and providers) in southern California, mainly Los Angeles, where a much higher proportion of the population was Latino relative to the rest of the state.

8 See Section 3.1 for more information about provider enrollment and disenrollment trends and cost avoidance due to provider disenrollment.

Figure 2.1.2:
Race/Ethnicity Comparison of California Population to Family PACT Population, 2003[a]



a The "Asian" category includes Filipino and Pacific Islanders. "Other" includes Native Americans.
b Population between age 10-55 for females and 10-60 for males.
Family PACT data source: FPACT paid claims and client enrollment data.
CA source data: Current Population Survey, March 2003 Annual Social and Economic Supplement. Conducted by the Bureau of Census for the Bureau of Labor Statistics, Washington DC, 2003.

The overall proportion of clients served in Family PACT by race/ethnicity changed very little between 1999 and 2003, with the exception of the Asian, Filipino, and Pacific Islander population. This group increased from four percent of the program's clients served in 1999 to six percent by 2003. New enrollment of providers – especially private providers – who specialize in serving Asian populations such as Hmong, Korean, Vietnamese, Chinese, and Filipino, appeared to contribute to the growth. The increase in the Asian, Filipino, and Pacific Islander population was seen program-wide, suggesting that other outreach strategies have been successful. Qualitative research on outeach strategies that have significantly contributed to the increase in Asian clients could provide valuable insight about successful outreach approaches.

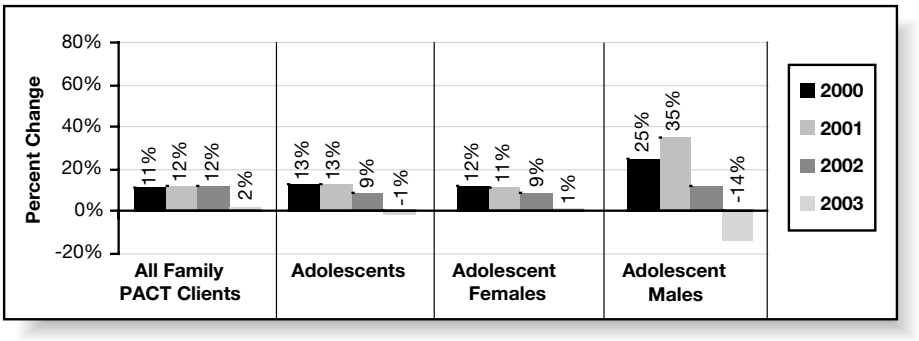
Sex, Age, and Language Preference

The distribution of Family PACT clients by sex and age shows that 71 percent were adult females, 17 percent were adolescent females, 10 percent were adult males, and two percent were adolescent males in 2003.[9] The average client age remained constant at about 26-years-old. Although more than half (52 percent) of all clients served spoke Spanish as their primary language, younger clients were more likely to report English as their primary language. Among adolescent clients in 2003, 27 percent reported Spanish as their primary language compared to 69 percent of clients age 35 and older.

Adolescents

From FY 1997-98 to 2003, adolescent female clients increased 87 percent (from 144,688 to 270,944), which was less than the overall program growth of 106 percent. Adolescent male clients increased 341 percent in the same period (from 7,211 to 31,796 clients), far greater than the overall program growth. Growth in the number of female adolescent clients ranged from 9 to 12 percent per year in the first three years of the waiver, before slowing to 1 percent in 2003. Annual growth in the number of male adolescents was more than double that of overall program growth in 2000 and 2001. In 2003 the annual growth rate for adolescent male enrollment declined by 14 percent (see Figure 2.1.3), which was consistent with program declines in male clients (described later in this section).

Figure 2.1.3:
Annual Growth Rates of Adolescent Clients Served, 2000-2003



Source: Family PACT claims and enrollment data

9 Adults are defined as clients age 20 and older; adolescents are clients age 19 and younger. Family PACT clients are eligible for services up to age 55 for females and age 60 for males.

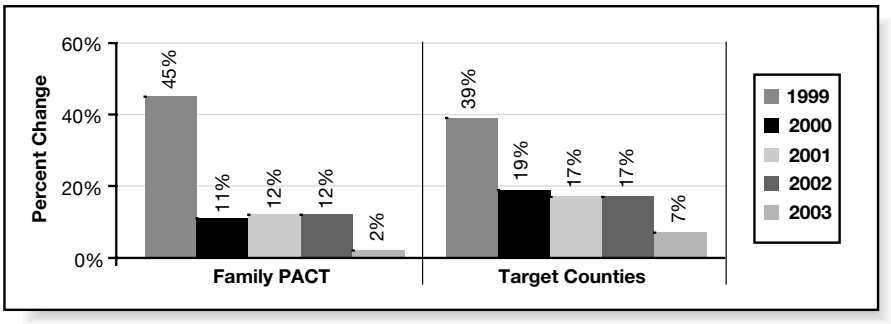
Target Counties – Geographic Areas of High Unmet Need

DHS-OFP selected 14 counties as geographic areas of high unmet need on which to focus targeted efforts to increase access to reproductive health services. The concept of "unmet need" refers to women who are at risk of unintended pregnancy[10] and are eligible for publicly funded family planning services but who did not receive such services. The 14 counties were selected based on data provided by UCSF on the level of unmet need and the number of eligible women in need per provider[11], as well as DHS-OFP's programmatic experience with qualitative factors affecting access in each county.

Clients served in the 14 designated target counties[12] increased significantly since program inception and collectively exceeded overall program trends. Nearly 380,000 clients from target counties were served in Family PACT in 2003, accounting for nearly one-quarter of all clients served in the program. Among all 14 target counties, clients increased 142 percent from FY 1997-98 to 2003 and 74 percent from 1999 to 2003.

Among all 14 target counties, the number of clients served per year showed steady growth in 2000, 2001, and 2002 (between 17 and 19 percent per year). In 2003, growth in the number of clients served slowed to seven percent; however, this growth was still well above the overall program growth of two percent (see Figure 2.1.4).

Figure 2.1.4:
Annual Growth Rates of Clients Served, Target Counties, 1999-2003



Source: Family PACT claims and enrollment data

Males

The number of male clients of all ages increased rapidly from the program inception until 2003, when it declined nine percent from 2002. Nearly 184,000 male clients were served in Family PACT in 2003. The number of male clients served increased 566 percent from FY 1997-98 to 2003 and 122 percent from 1999 to 2003. As a proportion of all clients served over the entire period, however, males increased from 4 percent in FY 1997-98 to 12 percent in 2003.

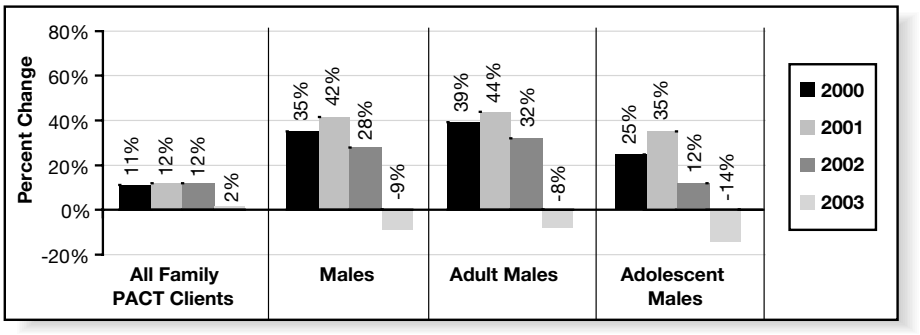
10 Women are considered to be at risk of unintended pregnancy if they are sexually active and neither pregnant, sterilized, postpartum, seeking pregnancy, nor infecund.

11 This data was provided in the report "Unmet Need for Family PACT Services FY97/98 to FY99/00" produced by UCSF. Counties were classified into four levels of unmet need and four levels describing the ratio of eligible women to providers using quartiles: very low, low, high, and very high.

12 Alpine, Fresno, Imperial, Mariposa, Orange, Placer, Riverside, Sacramento, San Bernardino, Sierra, Solano, Ventura, Yolo, and Yuba Counties. Target counties were identified by DHS-OFP; UCSF provided county-level data for this process.

Growth trends for males in 2000 and 2001 were considerably higher than overall program trends and were largely attributable to an expansion in program benefits to male clients as well as specialized outreach efforts directed towards this population. Annual growth trends among adolescent males were slightly less rapid as for adult males, but were still higher than overall program trends through 2002 (see Figure 2.1.5). While a decline in male clients occurred between 2002 and 2003, this drop was attributed to provider disenrollment and slow growth in new provider enrollment, as opposed to the absence of need among low-income males.

Figure 2.1.5:
Annual Growth Rates of Male Clients Served by Age Group



Source: Family PACT paid claims and enrollment data

Summary

Growth in clients served occurred among all racial/ethnic, sex, and age groups, and among women in geographic areas of high unmet need. The male client growth rate exceeded the female rate in all years prior to 2003.

Section 2.2: *Client Outreach Strategies*

Key Findings:

- The TeenSMART Outreach Program reached thousands of adolescents through group presentations and one-on-one outreach, and received family planning visits from more than 26,000 teens.
- The most readily sustainable client outreach tool is the toll-free Family PACT Information and Referral Line.
- There was a direct impact between the Statewide Media Campaign television broadcast dates and the exponential increase in calls to the toll-free Information and Referral Line.

Strategies for Outreach to Target Populations

The goal of client outreach activities was to increase client enrollment in Family PACT, particularly among the three target populations identified in the CMS waiver demonstration project: adolescents, males, and women in geographic areas of high unmet need. Additionally, the Demonstration Objectives included the goal to increase the number of Family PACT providers in unserved/underserved areas through new and innovative recruitment strategies that were customized for local or regional characteristics.

While DHS-OFP implemented numerous outreach activities, including direct-to-client contact and outreach through providers and CBOs, UCSF evaluated only the toll-free phone line call volume and the TSO Program. This section summarizes findings from those two studies, using data from call volume and program progress reports.

TeenSMART Outreach (TSO)[13]

DHS-OFP's TSO Program provided dedicated funds to Family PACT providers to conduct grassroots outreach efforts aimed at promoting the awareness and increasing the use of family planning services among young women and men, particularly those with high-risk sexual behaviors. Approximately 20 to 25 public Family PACT providers received TSO funds each year since 1998. In FY 2002-03, DHS-OFP contracted with UCSF to evaluate the TSO Program as part of the overall evaluation of Family PACT.[14]

During the first half of FY 2004-05, TSO staff reached nearly 17,000 youth through 800 group presentations, and nearly 19,000 youth through one-on-one outreach activities. Additionally, they trained 223 youth to become peer educators or outreach workers. To increase referrals of teens to their clinics, TSO programs established linkages with schools, CBOs, county social service departments, and other groups that serve high-risk teens. TSO programs contacted 571 community organizations, made 339 presentations, and signed 68 referral agreements during the reporting period.

Community activities targeted both the general community (to increase awareness of the importance of teen pregnancy prevention) and teens directly (to promote access to services). TSO programs developed many new materials including more than 1,000 flyers, brochures, and handouts, 34 ads, Public Service Announcements, posters and billboards, and 19 other informational items. Additionally, staff participated in 97 health fairs and other events, which reached nearly 9,000 participants.

Prior to 2004 monitoring, ad hoc reports showed that when the contract period changed in 1998, TSO agencies that lost their outreach funding were unable to maintain the same level of growth in adolescent clients as Family PACT providers as a whole (1 percent growth versus [vs.] 16 percent in Family PACT). Those agencies that began to receive outreach funding exceeded the overall growth in adolescent clients in Family PACT (21 percent growth vs. 16 percent in Family PACT).

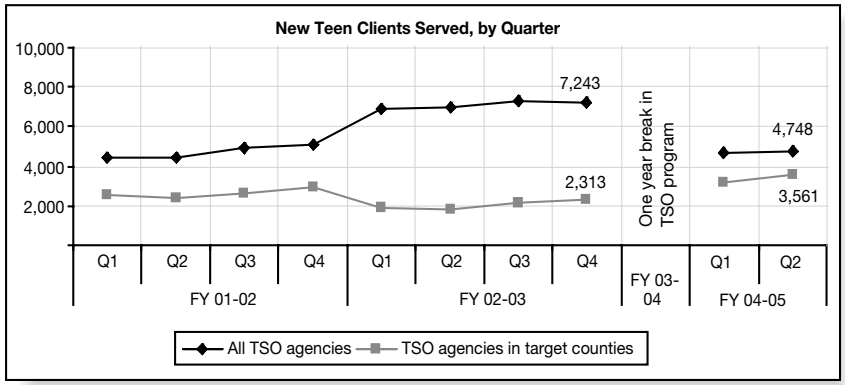
Many Planned Parenthood clinics were Family PACT providers, and some were also TSO agencies. Client demographics were essentially the same between the Planned Parenthood sites that were TSO agencies and those that were not. However, there were differences in client demographics between TSO and non-TSO agencies that were not also Planned Parenthood providers: the TSO agencies attracted relatively more White, English-speaking and young clients, and fewer Latinos.

13 DHS-OFP is transitioning to the use of "adolescent" instead of "teen" with the recent expansion of the Maternal and Child Health Branch to the Maternal, Child, and Adolescent Health Branch. However, the terms "adolescent" and "teen" are used interchangeably within the Branch and in this report when describing existing programs that serve clients under age 20.

14 Due to a break in program funding during FY 2003-04, TSO evaluation data is available for FY 2002-03 and the first half of FY 2004-05 (July-December 2004).

Teen client enrollment is an important indicator of TSO Program impact. During the first half of FY 2004-05, TSO programs reported that more than 26,000 clients aged 19 and younger visited their clinics to receive family planning or reproductive health care. Two-thirds of these clients were seen by the six agencies based in Family PACT waiver target counties. Nearly 40 percent of all teen clients seen statewide were visiting the clinic for the first time.

Figure 2.2.1:
Trends in Number of New Teen Clients Served By Clinics Receiving TSO Funds



Source: TSO Progress Reports

Figure 2.2.1 shows recent trends in the number of new teen clients (i.e., those making their first visit) served at clinics with TSO funding. This figure decreased among target county TSO agencies in FY 2002-03, most likely due to the voluntery disenrollment of one provider from the TSO program.

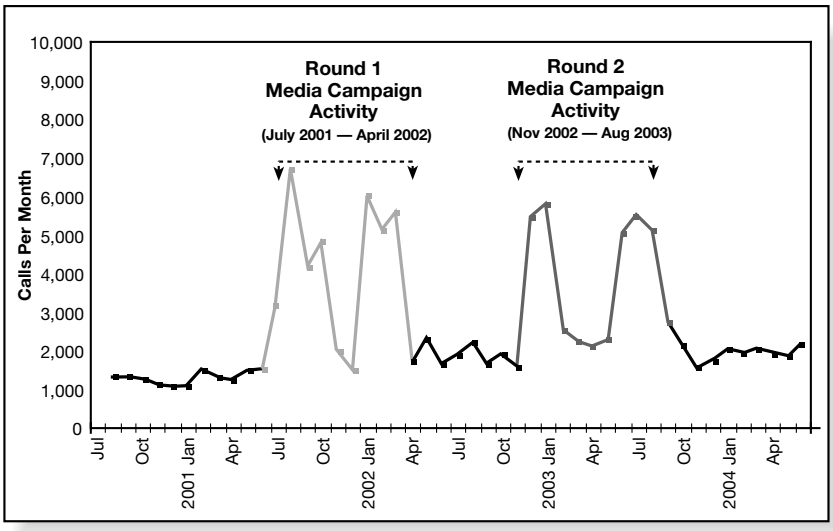
FY 2002-03 surveys indicate that most new teen clients heard about the clinic from their friends (63 percent), from a presentation about the clinic (33 percent), or from someone who worked for the clinic (22 percent). When asked what they would have done if they could not have come to the clinic for family planning services, the majority (55 percent) stated that they did not know how they would have proceeded; 16 percent reported they would have seen their family doctor; 14 percent would not have received any care at all; and 11 percent would have gone to another clinic.

Statewide Media Campaign

The Family PACT media campaign was launched across California in April 2001 and ran through August 2003.[15] This campaign was designed to serve as the primary outreach strategy for adolescents who potentially qualified for but were not enrolled in Family PACT.

The media campaign, particularly the broadcast dates of television and radio ads, had a direct and immediate impact on calls to the toll-free Family PACT Information and Referral line.[16] Utilization of this service grew exponentially (see Figure 2.2.2).

Figure 2.2.2:
Media Campaign Activity - Monthly Call Volume, July 2001-May 2004



Source: SBC Call Volume reports for August 2000-June 2004

15 For a full report on the campaign, please see "An Evaluation of the Department of Health Services Teen Pregnancy Prevention Campaign: Survey of Adult Californians," July 10, 2002, Field Research Corporation for Runyon, Salzman & Einhorn, and "An Overview of the Evaluation of the Department of Health Services Teen Pregnancy Prevention Campaign: Two Surveys — One of Adult Californians and One of California Teens."

16 From the inception of the Family PACT Program, DHS-OFP has maintained a toll-free Information and Referral telephone line as a resource for clients. The automated telephone service provides information on Family PACT services in multiple languages and includes a zip-code-based provider directory for callers to locate their closest Family PACT provider.

In the six months between August 2001 and January 2002, there were 18,000 more calls than during the same period the previous year (25,000 compared to 7,000). During November 2002 through January 2003, the English, Spanish, and Vietnamese language lines experienced the most substantial call volume increases: 294 percent, 140 percent and 1,500 percent, respectively. Continued high call volume for January through June 2003, especially among the Spanish and English lines, suggests the media campaign continued to positively impact awareness of the Family PACT program. Following the media campaign, call volume resumed a more typical pattern, although it remained higher than prior to the campaign by about 1,000 calls a month.

Outreach Activities Not Evaluated by UCSF

DHS-OFP conducted outreach efforts that were not included in the UCSF SOW for evaluation or monitoring. However, UCSF investigators participated in many of these activities and recognized their value. Summaries of this outreach follow:

Client-focused activities: UCSF staff participated in the Family PACT Outreach Task Force (OTF) convened by DHS-OFP between February 2000 and early 2004, to explore linkage opportunities between Family PACT and other state programs that served the targeted populations identified in the waiver Demonstration Objectives. The OTF was an uncommon collaboration of 15 statewide programs with similar interests and clientele that addressed family planning-related issues including youth development, school health services, STI, rural health, and male services. The most important outcomes of the OTF were the consolidation of TPP programs and the development of additional clinical links to them. DHS-OFP should consider reconvening the OTF, particularly in times of scarce resources for outreach activities for all DHS programs. Strictly speaking, the OTF was a component of Family PACT infrastructure as opposed to outreach; such collaboration does, however, have the potential to develop formal client outreach activities.

An additional client-focused outreach activity was the Community Action Network (CAN), a component of the media campaign that provided community organizations throughout California with opportunities to guide, advise, evaluate, and extend the reach of the campaign through locally developed strategies. With first-hand knowledge of their communities, CAN members were able to extend the campaign's social marketing messages to target audiences. Although UCSF had no involvement in CAN or its evaluation, Runyon, Salzman & Einhorn's reports indicate that it was a cost-effective and dynamic strategy for widespread Family PACT name recognition. Should similar activities be planned in the future, a coordinated evaluation could assess their impact on Family PACT client enrollment.

Provider-focused activities: Outreach strategies to providers have a direct effect on clients; when more providers are enrolled and retained, more clients can enroll and receive services. Through DHS-OFP contracts with The Center for Health Training and the California Family Health Council, provider outreach has included program marketing and promotion, recruitment, orientation, continuing medical education and support services, technical assistance, and program linkages.

Several mechanisms have also been created to enable providers to incorporate Family PACT services into their overall practices. These included online resources, on-site assistance, presentations, print media, provider forums, and audio-teleconferences. Ultimately, provider outreach and service integration efforts aimed to attract as many new providers to the program as possible, and to support them in reaching the greatest number of eligible clients with high quality clinical services.

UCSF staff participated in committees that developed components of initiatives such as the curriculum for Orientation and Update Sessions, Client-Oriented Provider-Efficient (COPE®) training, Web-based training modules (e.g. Family PACT 101), audio-conference training materials, and the identification of experts in family planning for presentations and newsletter articles.

Additionally, UCSF statisticians and staff participated in or attended all Regional Provider Forums presenting statewide and regional data on provider and client enrollment and trends in contraceptive method utilization, particularly emergency contraception. Beginning in 2005, findings of the five-year program evaluation were presented at these events. From the inception of the waiver through July 2005, 22 forums had been conducted, reaching more than 600 attendees who represented more than 300 provider entities.

UCSF analysts also created county-level maps that were used by DHS-OFP as part of the Regional Provider Forums to assist providers with marketing their practices to clients. The maps were offered to the attendees so they would know where to focus marketing, outreach, and potential additional practice sites. As a result of demand for electronic versions of the maps, they were expanded to cover the entire state and posted on the Family PACT website. The maps had not been updated as of July 2005; given their past appeal to providers, DHS-OFP should revise the maps and post them on the website in addition to using them in forums and other presentations.

UCSF has also participated in the revision of the Client Enrollment Certification (CEC) form, which included a new data field asking clients how they found out about Family PACT. This information can guide outreach strategies tailored to specific groups of clients and geographic areas.

Assessing ongoing education and support services for providers has been a challenge. While providers complete evaluation forms after attending orientations and Regional Provider Forums, the transmission of this information to evaluators has been inconsistent. Also, while the contacts made from direct mailings have been tracked, there are no data available on provider enrollment as a result of the mailing. It may be useful to conduct cost-benefit analyses of recruitment activities. In addition, it will be important for DHS-OFP to establish processes of data transfer that will allow timely appraisals and subsequent interventions to improve provider enrollment and service delivery.

Summary

Investing in provider outreach appears to have been received favorably by enrolled and potential providers. Client outreach activities reached thousands of adolescents through the TSO program and the evaluation of the Media Campaign demonstrated that it was very effective in garnering name recognition of the Family PACT Program. However, data do not exist to evaluate the direct impact of the Media Campaign on enrollment. Future campaigns should incorporate an assessment of the effectiveness of outreach strategies on client enrollment in Family PACT. Activities not evaluated, such as CAN, should be assessed for their future potential value to Family PACT.

Section 2.3: *Client Satisfaction*

Key Findings:

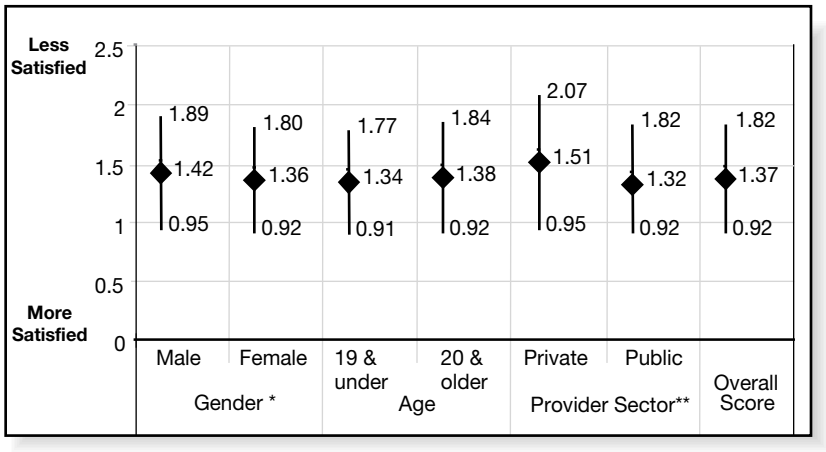
- Eighty-eight percent of clients reported being "very satisfied" with their experience with a Family PACT provider; an additional 10 percent were "somewhat satisfied."
- Ninety-eight percent of clients would recommend their provider to their family or friends, and 89 percent would return to that provider in the future.
- Eighty-nine percent of clients were satisfied with the birth control choices available to them.
- Almost all clients were satisfied with their privacy when speaking to the clinician (99 percent) and with clinic staff (91 percent).
- Seventy-eight percent of clients felt comfortable in the waiting room, although areas for improvement were also indicated.
- Clients spent an average of 48 minutes in the waiting room; about 15 percent of clients felt this waiting time was "too long."

Overall Satisfaction

Client satisfaction was assessed using the Client Exit Interview (CEI).[17] CEI findings show that Family PACT appeared to be well-received by users of services. Almost all clients were "very satisfied" (88 percent) or "somewhat satisfied" (10 percent) with the overall clinic experience, would recommend the clinic to family or friends (98 percent), and were very likely to return to the clinic (89 percent). Only two percent felt it was unlikely they would return to the clinic, primarily because of an inconvenient clinic location, a clinic not being their regular health provider, and concerns about appointment availability.

These high levels of satisfaction were mirrored in a constructed "satisfaction" score that rated client agreement (1=completely agree; 5=completely disagree) with statements about staff courteousness and attentiveness, clinic appearance, time spent with a doctor, and communication with a doctor. Score distribution was skewed towards 1 with a mean score of 1.37 (±0.45), suggesting overall satisfaction with quality of services. Female clients and clients at public providers were slightly, but statistically significantly, more satisfied than male clients ($p<.05$) and clients at private providers ($p<.001$; see Figure 2.3.1).

Figure 2.3.1:
Mean Overall Satisfaction Score, by Gender, Age, Provider Sector (N=1,469)



*Source: Client Exit Interviews, 2004 *p<.05; **p<.001*

17 The 2004 CEI are designed to: 1) assess client satisfaction with Family PACT services; 2) describe the contraceptive practices of clients; and 3) examine provider adherence to selected program and national standards of care. This study builds upon previous Phase I Family PACT evaluation studies. Sixty-eight providers (75 percent public sector and 25 percent private sector), in 13 counties were randomly selected to participate in the CEI study during fiscal year 2003-04. Clients responded to an exit interview at the provider's site upon completion of their Family PACT visit. Clients interviewed numbered 1,472 (1,221 females [400 age 19 and under] and 251 males [50 aged 19 and under]).

Clients also answered questions about their satisfaction with the following aspects of care:

Scheduling Appointments: More than half (52 percent) of clients were able to make same-day appointments or were walk-ins, and 77 percent were seen within a week of contacting the provider. There was no difference between public and private providers in the average length of time clients had to wait to make an appointment. These findings indicate that providers are generally meeting the Family PACT Standard that a client be seen "within a reasonable time period, or less than three weeks" from initial contact.

Waiting Time: The average length of time clients waited to be seen at their visit was 48 minutes, with no difference between public and private providers. About 31 percent of CEI respondents indicated that their wait time was "long, but OK;" 29 percent said they were seen quickly; 25 percent thought the wait was "neither long nor short;" and 15 percent thought the wait was "too long." Waiting time was the most common complaint among client responses to the open-ended question at the end of the interview, "Is there anything else you would like to add?"

Clinic Atmosphere: The majority (78 percent) of clients were comfortable in the waiting room, with no difference between public and private providers. About one-fifth (22 percent) offered some critique of waiting room. Ten percent expressed dissatisfaction with space, noise level, and temperature; seven percent with the entertainment provided (including availability of reading materials and television); the remaining five percent cited factors related to other clients (e.g., lack of others of same age, lack of men, too many men, crowd too heterogeneous/homogeneous), privacy issues, slow service, and unavailability of drinks and snacks. These complaints indicate a need for improvement in waiting rooms, particularly with regard to privacy, as nine percent of clients were "somewhat" or "very" dissatisfied with this aspect of their visit.

Language Proficiency: Most (93 percent) clients indicated that the clinician spoke their preferred language. Clients at public providers were more likely to indicate that the provider spoke their preferred language compared to those at private providers (94 percent vs. 89 percent). Among clients for whom the provider did not speak their language (n=103), 57 percent had the communication facilitated by a third party (e.g., interpreter, friend, another family member), and 43 percent spoke English, but would have preferred to speak their native language.

Privacy: Nearly three-quarters (72 percent) of clients were "very satisfied" and 19 percent were "somewhat satisfied" with the privacy afforded by the staff. Almost all (95 percent) clients felt "very satisfied," and an additional four percent were "somewhat satisfied," with clinician-client privacy. Clients seeing private providers were more likely than those seeing public providers to be "very satisfied" with staff-client privacy (78 percent vs. 70 percent), but less likely to be "very satisfied" with physician-client privacy (91 percent vs. 97 percent) (see Figure 2.3.2).

Figure 2.3.2:
Proportion Highly Satisfied with Staff and Clinician Privacy, by Age, Gender, and Provider Sector

	Age		Gender		Provider Sector		Total
	age 19 (N=450)	age 20 (N=1022)	Male (N=250)	Female (N=1222)	Private (N=363)	Public (N=1109)	(N=1472)
Staff	72%	72%	67%	73%	78%*	70%	72%
Clinician	95%	96%	93%	96%	91%	97%*	95%

*Source: Client Exit Interviews, 2004 *p<0.05*

Availability of Contraceptive Services:
Respondents indicated high levels of satisfaction with the contraceptive services offered by their providers. Eighty percent said they were "very satisfied" and nine percent said they were "somewhat satisfied" with the birth control choices offered by their provider. Greater proportions of female, adolescent, and public sector clients reported being "very satisfied" compared to male, adult, and private sector clients. Only 10 of the 1,472 clients interviewed (less than one percent) were dissatisfied with the discussion of method choices. The reasons for dissatisfaction among these few clients were: the provider did not review the various methods (n=5); the methods offered did not meet the client's personal needs (n=3); and the desired brand was not available (n=2). None of the clients for whom their preferred method or a brand was unavailable were referred to another provider. Although this is a relatively small number of clients, the reasons referrals were not made require follow-up.

Summary

The UCSF CEI indicates that Family PACT clients are pleased with program services overall. Availability of contraceptive services and language proficiency at clinics received the highest satisfaction ratings. Convenient appointment times, clinic atmosphere, and privacy were also favorably reviewed by survey respondents. More female and private sector clients were highly satisfied with privacy compared to male and public sector clients.

Section 3.1: *Provider Enrollment and Participation Trends*

Key Findings:

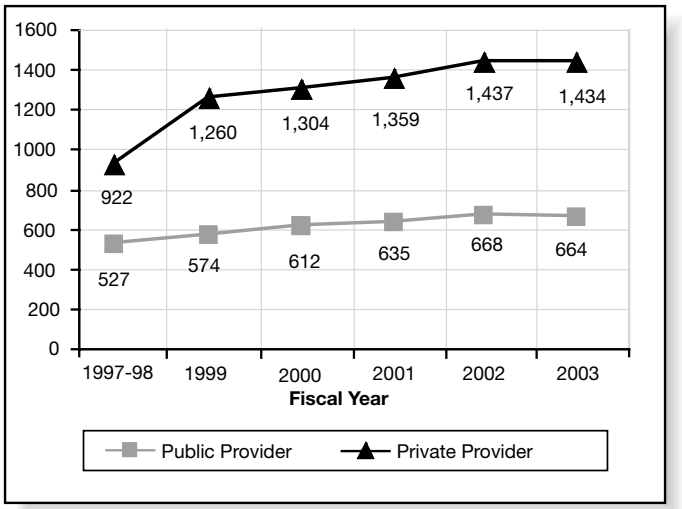
- Family PACT had more than 2,000 providers delivering services to clients in 2003, an increase of 45 percent over the nearly 1,500 providers delivering services in FY 1997-98.
- There were more than twice as many private providers compared to public providers, but the latter served 60 percent of all clients.
- As of mid-2005, 85 Family PACT providers had been disenrolled from the program as a result of DHS-OFP monitoring activities.
- By the completion of FY 2003-04, an estimated $65.5 million in cumulative cost aversion to Family PACT were realized.

Overall Growth in Enrolled and Delivering Providers[18]

Family PACT claims data have been used to monitor trends in provider enrollment and participation. Enrolled clinician providers rose from 2,135 in FY 1997-98 to 3,029 in 2003, a 41.9 percent increase. Over the same period, delivering public providers represented between 84 and 86 percent of enrolled public providers, while delivering private providers composed between 61 and 64 percent of enrolled private providers.

The program had 2,098 providers delivering services in 2003, a 44.8 percent increase over the 1,449 providers delivering services in FY 1997-98. Growth in the number of delivering providers occurred each year, until a slight decrease of 0.3 percent occurred between 2002 and 2003. Private providers comprised roughly two-thirds of all delivering providers each year. However, on average public providers served about 60 percent of all clients.

Figure 3.1.1:
Number of Delivering Clinician Providers by Public/ Private Status in Family PACT, FY 1997-98 to 2003



Source: Family PACT claims data

Strong provider growth was accomplished through the use of innovative recruitment tactics including presentations and exhibits, print media campaigns, audio teleconferencing discussing clinical and program administrative topics, and access to application materials and orientation information via the Family PACT website. Family PACT offered on-site technical assistance, promotional materials for client outreach, and ongoing education and telephone support services. Outreach is discussed in more detail in Section 2.1.

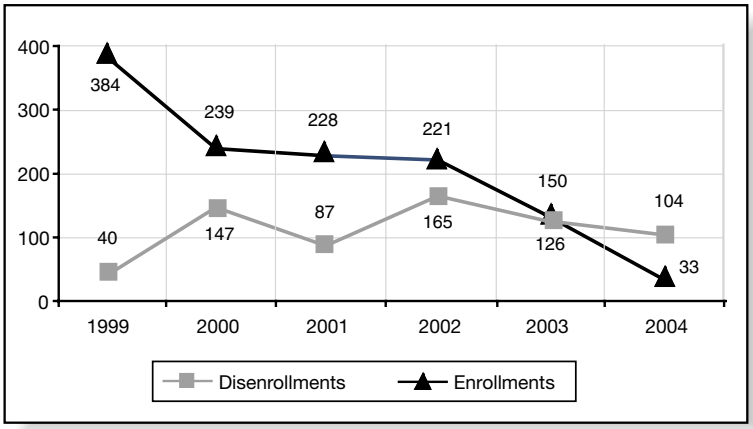
Provider Transitions

The number of provider enrollments was generally greater than the number of disenrollments, both voluntary and involuntary.[19] The reversal of this pattern in 2004 can be attributed in part to DHS-OFP administrative problems with processing provider enrollment applications, which were resolved by mid 2005. Despite the reversal, the overall trend in provider enrollments has slowed over time (see Figure 3.1.2).

18 A delivering provider is defined as a clinician provider who has had at least one paid Family PACT claim in a given year. An enrolled provider, in comparison, is a clinician who has received a Family PACT provider identification number, but who may or may not have had any paid Family PACT claims in a particular year.

19 Disenrollment can be voluntary (e.g., a provider chooses to stop participating in the program or moves out of state) or involuntary (e.g., due to non-compliance with program regulations or other reasons as deemed appropriate by Medi-Cal). In the discussion on provider transitions, both groups are included in the findings. UCSF was able to determine transitions based on provider identification numbers, but was not able to determine the reason why a provider left the program. UCSF also did not have the data to determine how many disenrollments were voluntary and involuntary; this information is collected and maintained by the DHS-OFP Program Integrity team and the Medi-Cal Audits and Investigations Unit.

Figure 3.1.2:
Trends in Family PACT Provider Enrollments and Disenrollments, 1999-2004



Source: Family PACT claims data

is hypothesized that these disenrollments have had minimal impact upon legitimate access.[21] Further study may elucidate the relationship between removing fraudulent or abusive providers and retaining access for Family PACT clients.

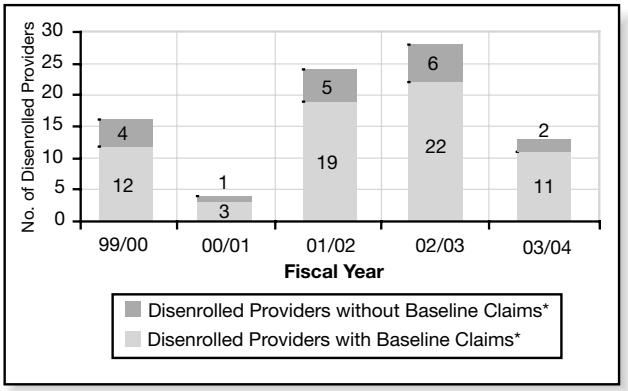
Seventy-six percent of provider disenrollment occurred in FY 2001-02 or later. The year with the largest number of disenrollments was FY 2002-03 and the year with the fewest was FY 2000-01. With the notable exception of FY 2000-01, disenrollments have been steadily increasing over time as the PI team successfully identified non-compliant providers (see Figure 3.1.3).

Involuntary Provider Disenrollment from Family PACT due to Program Integrity Issues

A separate issue from providers choosing to discontinue service provision is the involuntary disenrollment that occurs when DHS determines that a provider is ineligible to participate in Family PACT, or more generally, the Medi-Cal Program. DHS may also restrict participation through administrative sanctions predicated on regulation. Providers are subject to removal from the Family PACT Program by DHS-OFP for failure to adhere to program policies and administrative practices.[vi] Efforts by the DHS-OFP Program Integrity (PI) team to detect and document provider non-compliance with regulations and policies may have resulted in referral to the Medi-Cal Audits and Investigations Unit in addition to disenrollment from Family PACT. These efforts were not conducted by UCSF and used different data than those analyzed by UCSF in the provider transition studies described above.

Between 1999 and 2004, 85 Family PACT providers, comprising 191 provider identification numbers,[20] were disenrolled from Family PACT as a result of PI team activities. When a provider's enrollment in the Family PACT Program is terminated, Family PACT services are no longer reimbursable. Available data could not determine to what extent the disenrollment of providers for noncompliance affected clients' access to services. However, because disenrolled providers were not likely to have been providing services to eligible clients it

Figure 3.1.3:
Number of Disenrolled Family PACT Providers, FY 1999-2000 – FY 2003-04



*Baseline claims are defined as paid claims one year prior to provider disenrollment.

Source: Family PACT claims data

20 Usually a provider number represents one site, but it is possible that it may represent several sites.

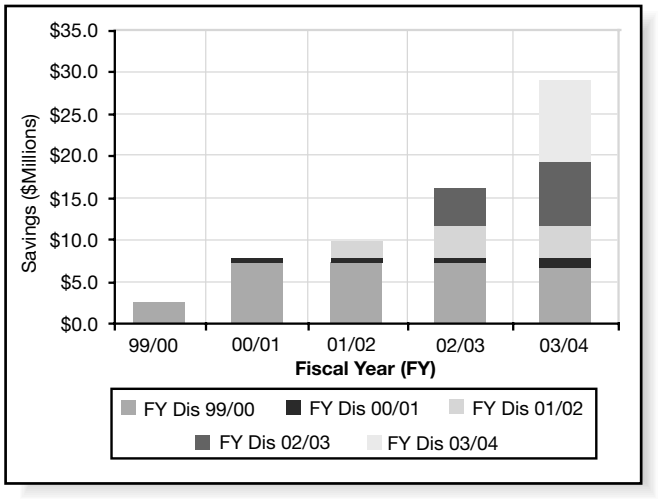
21 Disenrolled providers often resulted in savings to Family PACT because many of these providers had not been furnishing valid services to clients. Disenrollment for gross and unsubstantiated over-billing or for submitting charges for unconfirmed clients are two means that may have generated savings to the program.

Cost Avoidance from Disenrollment of Noncompliant Providers

To measure reimbursements avoided by provider disenrollment, all Family PACT reimbursements paid for services rendered to that provider's client-base were examined. This client-based approach included reimbursements for clinician services as well as off-site pharmacy and laboratory services, which made up roughly two-thirds of all Family PACT reimbursements each year.[22] In addition, the method adjusted the estimated cost avoidance by accounting for reimbursements accrued by the clients of disenrolled providers who continued to receive Family PACT services from other providers. Finally, the cost avoidance calculation included an estimation of the services rendered to future clients had the provider not been disenrolled. Savings were estimated for each fiscal year after disenrollment, as opposed to a one-time only savings, based on the assumption that providers would continue to serve clients had they not been disenrolled. The detailed methodology for cost avoidance calculations can be found in Appendix III.

Using this methodology, 67 of the 85 disenrolled providers had sufficient data upon which to calculate savings.[23] Given that any provider disenrollment had continuing effects into the future, it is not surprising that the cost avoidance figures increased over time. For example, providers disenrolled in FY 1999-00 contributed between $6 and $8 million in saved reimbursements per year from FY 2000-01 forward. The disenrollment activities of FY 2002-03 and FY 2003-04 were estimated to save nearly $18 million in FY 2003-04 alone. This is significant because the increased provider disenrollments in later years will have a substantial effect on cost avoidance that will be realized into the future (see Figure 3.1.4).

Figure 3.1.4:
Estimated Annual Cost Avoidance Resulting from Disenrolling Family PACT Providers, FY 1999-00 – FY 2003-04



Note: The shading variations in each column represent the portion of estimated savings that can be attributed to a particular fiscal year's disenrollment efforts.

Source: Family PACT claims data

Summary

The number of delivering providers rose almost 45 percent from program inception to the end of 2003, but the number of newly enrolled providers decreased after 1999 and was lower than the number of disenrolled providers in 2004. There were more private providers than public, but public providers served more clients. Efforts to disenroll non-compliant Family PACT providers had positive and long-lasting fiscal outcomes. While UCSF has demonstrated the cost savings of disenrolling providers, it was not possible to confirm to what extent the removal of these providers affected clients' access to services. More information about the potential effects of provider disenrollments on clients served is presented in Section 2.1.

22 Family PACT Program Annual Report FY 2001-02.

23 If a provider does not have any paid claims in the year prior to disenrollment, then there are no baseline reimbursements. Consequently, it was assumed that there were no savings as a result of the disenrollment. This was the case for 18 of the 85 disen rolled providers in this analysis.

Section 3.2: *Collaborative Partnerships and Referrals to Family PACT*

Key Findings:

- More than 60 percent of organizations serving low-income populations in California have heard of Family PACT. Organizations in rural communities and those not receiving DHS-OFP funding were significantly less likely to know of Family PACT, indicating priority areas to target with outreach and coordination efforts in the future.

- Nearly all (94 percent) DHS-OFP-funded TPP programs provided information about clinical family planning services to their teen participants, and 87 percent referred teen participants to family planning providers using formal referral mechanisms.

- DHS-OFP's requirement that some TPP programs link their participants to Family PACT services beginning in FY 2003-04 was associated with stronger collaborative partnerships and a greater number of referrals.

- Insufficient resources, lack of DHS-OFP guidance, and disinterest on the part of Family PACT providers affected at least 20 percent of TPP programs in their attempts to build partnerships with and refer teen participants to Family PACT providers.

Introduction

Between 1999 and 2003, DHS-OFP promoted linkages between Family PACT providers and other organizations serving low-income populations. These efforts aimed to stimulate growth in client enrollment by facilitating collaboration, supporting referrals, and identifying additional opportunities for outreach.

In 2000, DHS-OFP convened an OTF to explore possibilities for linkages between Family PACT and other statewide programs for low-income women, men, and adolescents. Based on the suggestions of the OTF, DHS-OFP embarked on various linkage activities, including presentations to allied programs about the importance of family planning, the development and distribution of promotional materials, and the distribution of formal DHS letters to encourage collaboration. Beginning in FY 2003-04, DHS-OFP made it a condition of grant funding that some of its TPP programs collaborate with and refer their participants to Family PACT providers. This requirement went into effect in FY 2004-05 for all TPP programs, though data for that year are not yet available for analysis.

UCSF conducted two surveys to assess the level of awareness of and referrals to Family PACT providers: 1) a survey of CBOs that served low-income adults and adolescents likely eligible for Family PACT services (n=216); and 2) a survey of coordinators of DHS-OFP-funded TPP programs that provided educational services to adolescents in communities with high teen birth rates (n=138). The findings from these data sources are described in this section.

Coordination with Community-Based Organizations (CBOs)

CBO AWARENESS OF FAMILY PACT

UCSF findings indicate that many health, social service, education, and employment organizations have heard of the Family PACT Program, knew of a Family PACT provider in their community, and could correctly identify Family PACT services and eligibility requirements. However, differences in these outcomes existed, particularly by geographic location and funding source.

Overall, 60 percent of CBOs reported that they had heard of Family PACT, with significantly more organizations from urban than non-urban communities having heard of the program (65 percent vs. 49 percent, $p<.05$). Not surprisingly, organizations that received funding from DHS-OFP were significantly more likely to have heard of Family PACT (94 percent vs. 42 percent, $p<.001$) and to be a Family PACT provider (56 percent vs. 24 percent, $p<.001$) than organizations that did not receive such funding. These findings suggest that while efforts to increase referrals and access to care have been successful in increasing awareness about Family PACT, reaching rural communities and organizations funded outside of DHS-OFP have posed greater outreach challenges. The findings also echo other studies on inter-agency linkages that have found that referrals are less common among organizations providing dissimilar services.[vii]

Most CBOs that had heard of Family PACT could correctly identify the groups that are eligible for Family PACT services. While CBOs demonstrated a great deal of knowledge about the services available under Family PACT, more than one-third perceived the scope of services to be broader than they actually were. Educational efforts are needed to increase organizations' understanding of the types of services available through Family PACT, as well as the program's eligibility requirements.

While the largest proportion of CBO staff had heard about Family PACT through their workplace, one-fifth learned about the program through the mass media, suggesting that the former state-funded media campaign had been successful at increasing awareness about the program among both health care professionals and the target audience of eligible clients (see Section 2.2). Yet, as indicated by this study, collaborative partnerships also increased awareness about Family PACT in communities with unmet need. Almost all (97 percent) CBOs reported participating in collaborative partnerships with other organizations serving low-income populations. These partnerships have played an important role in sharing information and resources.

CBO REFERRAL PRACTICES AND EXPERIENCE

Approximately 82 percent of CBOs reported referring clients "often" or "very often" to other providers for health, mental health, and social services. Among the CBOs that had heard of Family PACT, about half (52 percent) reported that their organization had referred clients to a Family PACT provider. DHS-OFP-funded organizations were more likely than other organizations to refer clients of all types to Family PACT: females (90 percent vs. 75 percent, $p<.10$), males (84 percent vs. 63 percent, $p<.10$), and adolescents (89 percent vs. 70 percent, $p<.05$).

Most respondents felt that the organizations they represented were located in communities that supported family planning services for adults (90 percent) and adolescents (68 percent). Organizations located in non-urban areas, however, reported significantly less community support for adolescent family planning services compared to those in urban areas (54 percent vs. 75 percent, $p<.05$), making referrals much more challenging. Some CBOs reported other barriers to making referrals, including lack of information about resources available in the community (30 percent), lack of information about program eligibility (28 percent), and insufficient staff time (15 percent). Addressing these barriers will be important in improving the role of CBOs in increasing client referrals to Family PACT.

Coordination with TPP Programs

TPP Program Linkage Requirement

To promote access to family planning services for adolescents, DHS-OFP mandated that its TPP programs develop partnerships with Family PACT providers and implement referral systems to family planning services for their adolescent program participants. Local TPP programs were required to collaborate with at least one Family PACT provider in their community, with whom a formal system of referring adolescents was developed and agreed upon using a memorandum of understanding or subcontract. Among the three types of TPP programs, this requirement went into effect for the 27 Information & Education (I&E) grantees and 22 Male Involvement Program (MIP) grantees in FY 2003-04, and began for the Community Challenge Grant (CCG) grantees with the onset of the FY 2005-06 funding cycle.

TPP PROGRAM KNOWLEDGE OF FAMILY PACT

All TPP program coordinators had heard of the Family PACT Program, with most having gained this information through their organization (35 percent) or a DHS-OFP-led meeting (43 percent). The demonstrated potential of these mechanisms for disseminating information indicate that they could be used to provide updates about Family PACT eligibility and benefits to TPP program staff in the future. Given extensive staff turnover in CBOs, such trainings and updates are needed on a regular basis.

Additionally, 82 percent of coordinators stated that their organization had a list of the Family PACT providers in the county (or counties) they serve. Among these programs, 38 percent used the list at least once a week, and an additional 24 percent used it at least once a month. Among those coordinators who did not have a list of providers, the majority (60 percent) did not know that a list was available through DHS-OFP.

TPP COLLABORATIVE PARTNERSHIPS

Seventy percent of TPP program coordinators reported participating in formal collaborative partnerships with Family PACT providers. The majority reported that their partnerships with Family PACT were formalized through a letter of commitment (54 percent), common mission statement (34 percent), and/or contractual agreement (19 percent). Sixty percent met with Family PACT providers on a regular basis, in person or by phone.

Clinical linkage requirements affected the extent to which TPP programs collaborated with Family PACT providers. Only 58 percent of CCG programs (for which there was no linkage requirement until FY 2005-06) participated in a formal partnership with a Family PACT provider, compared to 95 percent of I&E and MIP programs (for which there has been a requirement since FY 2003-04). The number of providers with whom each TPP program worked was significantly greater for the I&E and MIP programs than for the CCG programs (4.0 vs. 2.2, p<.001).

TPP REFERRAL PRACTICES AND EXPERIENCE

Nearly all (94 percent) TPP program coordinators reported that their organization provided information on how to access clinical family planning services to those adolescents who needed them. Additionally, most (87 percent) programs referred their adolescent participants to family planning services. The linkage requirement was associated with a higher likelihood of referral. All I&E and MIP coordinators reported that their programs referred adolescents to family planning services, compared to 82 percent of CCG coordinators. Moreover, the number and proportion of adolescent participants referred were significantly higher for the I&E and MIP programs than for the CCG programs (see Figure 3.2.1). Subsequent evaluations will likely show greater referrals among CCG programs, given the recent implementation of a clinical linkage requirement for them.

Figure 3.2.1:
Information Provided and Referrals Made by TPP Programs

	All TPP Programs N=138	Programs without Linkage Requirement N=95	Programs with Linkage Requirement N=43
Percent informing teens about family planning services	94%	93%	98%
Percent referring teens to family planning services **	87%	82%	100%
Mean number of referrals in past month **	101	59	170
Proportion of participants referred in past month **	35%	26%	50%

**p<.01

The referral methods used by TPP programs varied, with the majority of coordinators stating that they "usually" or "always" relied on a community resource book (81 percent), used an established referral protocol (58 percent), distributed the Family PACT brochure (57 percent), and/or documented the referral (57 percent). Less often, a program staff person made the appointment for the adolescent participant (23 percent) and/or provided transportation assistance (20 percent). TPP programs with the clinical linkage requirement were more likely than those without it to use formal referral procedures (see Figure 3.2.2).

Figure 3.2.2:
Referral Practices to Family Planning Services

Percent responding that they "usually" or "always:"	All TPP Programs N=138	Programs without Linkage Requirement N=95	Programs with Linkage Requirement N=43
Maintain a community resource book	81%	80%	83%
Use an established referral protocol *	58%	53%	66%
Distribute the Family PACT brochure	57%	60%	52%
Call for an appointment *	23%	19%	31%
Provide transportation assistance	20%	17%	24%
Document the referral *	57%	51%	69%
Call provider to track participants ***	28%	17%	48%

*p<.05, ***p<.001

Successes and Challenges

Most TPP program coordinators felt that working with Family PACT providers benefited their program by helping them better meet participants' needs (94 percent), build their reputation in the community (92 percent), and provide better follow-up with family planning referrals (86 percent). Nearly all (97 percent) believed that their collaboration with Family PACT providers had reduced adolescent pregnancies in their communities, and most reported they were "very" (63 percent) or "somewhat" (29 percent) satisfied with their interactions with Family PACT providers.

However, coordinators also faced barriers in their attempts to partner with and refer participants to Family PACT providers. Fourteen percent reported past instances in which their attempts to develop partnerships with a Family PACT provider were unsuccessful. Inadequate resources about developing linkages, lack of structured guidance from DHS-OFP, and disinterest on the part of Family PACT providers affected at least 20 percent of TPP programs. In addition, parental beliefs and community norms about adolescent family planning continued to limit TPP programs' ability to refer participants to services, especially in more socially conservative communities.

Summary

DHS-OFP has made important steps in facilitating community collaboration and referrals by building awareness of the Family PACT Program and by strongly encouraging (and in some cases requiring) formal linkages between Family PACT providers and local organizations. Having a linkage requirement has had a clear effect on the development of collaborative partnerships and referral mechanisms between TPP programs and Family PACT providers. Because the goals, location, staffing, and target populations of the three types of TPP programs have been so similar, UCSF concluded that differences in referral practices were a result of the linkage requirement and not some other factor. Therefore, these differences are likely to diminish after the CCG agencies begin implementing their linkage requirement, and as they build skills and capacity for referrals.

Section 3.3: *Primary Care Referrals by Family PACT Providers*

Key Findings:

- Although primary care services are not covered by Family PACT, 88 percent of program providers offered wellness screenings, 63 percent referred clients to primary care, and 75 percent screened clients for public insurance eligibility.
- Barriers to referrals experienced by OB/GYN clinicians included difficulty finding providers to serve uninsured patients (68 percent), client resistance (42 percent), and difficulty finding providers able to accommodate clients' language requirements (26 percent).
- Barriers experienced by OB/GYN clinicians to screening clients for public insurance eligibility included client reluctance to disclose insurance status (42 percent) and staff unfamiliarity with eligibility requirements (36 percent).
- DHS-OFP can improve primary care referrals by giving providers information on local resources, offering trainings, and building partnerships with primary care organizations.

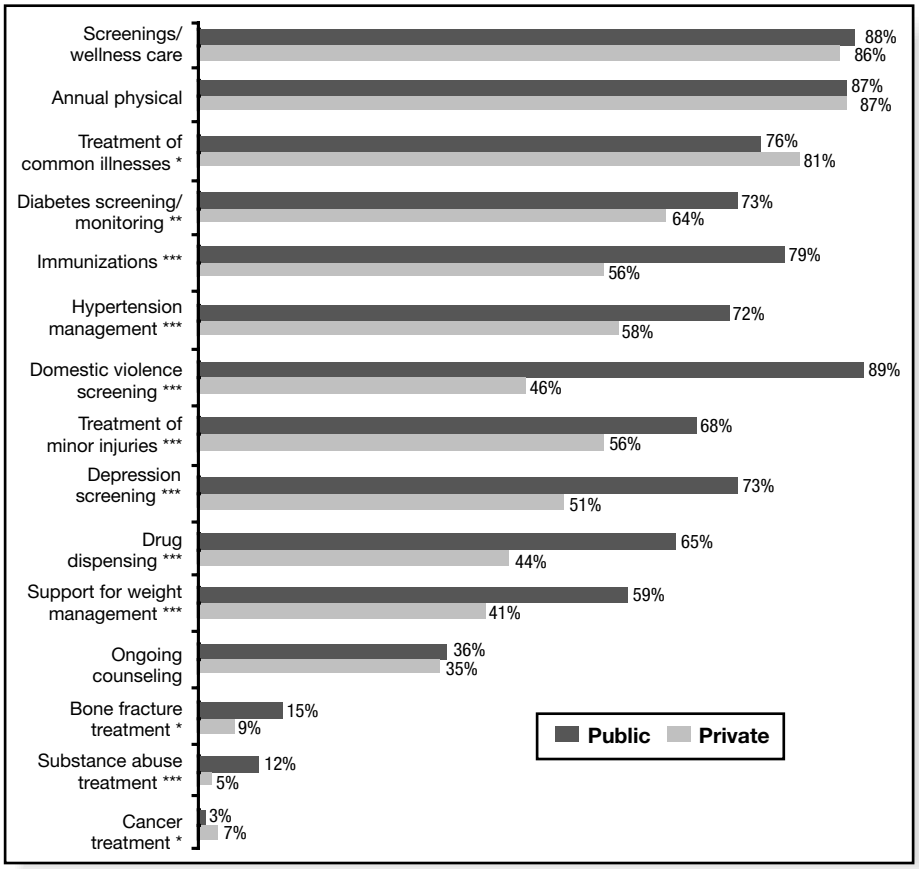
Purpose of the Provider Referral Study

Beginning in FY 2005-06, CMS required Family PACT to ensure access to primary care for clients. The Provider Referral Study collected baseline data on providers' referral practices in FY 2004-05 to help the program shape interventions with the potential to increase primary care referrals in the future. Seventy-five percent of providers who served 100 or more Family PACT clients in FY 2003-04 (n=950) participated. This section presents findings from the study.

Availability of Primary Care Services Onsite

While primary care services are not covered by Family PACT, most providers offered some level of primary care on-site, with a greater proportion of public than private providers offering such services (see Figure 3.3.1).

Figure 3.3.1:
Onsite Availability of Primary Care Services through Family PACT (n=950)



* p<0.05, ** p<0.01, *** p<0.001

Source: Provider Referral Study, 2005

Sixty-three percent of providers referred clients for primary care services. By specialty, 96 percent of family planning providers, 78 percent of OB/GYNs, 51 percent of general/internal medicine providers, and 45 percent of multi-specialty providers referred to primary care. These findings reflect that most general medicine and multi-specialty providers already provided many primary care services on-site.

Referral Practices

Among providers that gave referrals, 94 percent documented it in patient charts, 80 percent appropriately passed on records to the referral providers, 72 percent gave clients directions to referral providers, 63 percent completed a referral form, 51 percent followed up with clients to ensure they followed through, and 40 percent called to make appointments for clients. Although family planning and OB/GYN providers were more likely than other providers to give referrals, they were significantly less likely to engage in activities that enhanced the quality of these referrals. Only 47 percent of OB/GYN providers completed a referral form (vs. 65-76 percent of other providers, p<.001) and 33 percent followed up with clients to ensure they followed through (vs. 55-62 percent, p<.001). Family planning providers were the least likely to arrange appointments for patients (21 vs. 32-53 percent of other providers, p<.001) or give them directions (53 vs. 74-78 percent, p<.001).

Challenges to Providing Primary Care Referrals

Among the barriers providers faced in giving referrals were difficulty finding primary care providers to serve uninsured patients and client resistance to going to other facilities (see Figure 3.3.2). At least one-quarter of providers lacked basic resources, such as printed materials with the contact information of local primary care resources (32 percent), a community resource/referral book (26 percent), and/or a written staff referral protocol (23 percent). More than one-quarter (29 percent) also did not have informal referral networks with local primary care providers. OB/GYN specialists were the least likely to have these resources. Private providers were more likely than public providers to be unfamiliar with services offered by other health agencies (36 vs. 14 percent) and to lack information on how to facilitate referrals (31 vs. 12 percent).

Figure 3.3.2:
Barriers Experienced by Providers (n=950) in Referring to Primary Care, by Specialty

	General/ internal medicine	Multi-specialty or other	Family planning	OB/ GYN
Difficulty finding providers to serve indigent/ uninsured patients***	62%	57%	79%	68%
Client resistance to going to another facility	47%	47%	50%	42%
Inability of local primary care providers to take on new patients ***	32%	30%	41%	39%
Difficulty finding providers to accommodate clients language needs***	33%	33%	43%	26%
Inadequate staff time to complete paperwork and/ or track referrals	22%	18%	27%	26%
Difficulty finding providers who are teen-friendly ***	24%	16%	30%	29%
Difficulty finding providers who are male-friendly ***	15%	8%	19%	21%
Inadequate staff time during client visits to provide/discuss referrals	20%	13%	19%	18%
Unfamiliarity with services offered by other local health agencies **	29%	15%	22%	34%
Inadequate information on facilitating referrals to primary care ***	24%	12%	22%	31%

* p<0.05, ** p<0.01, *** p<0.001

Source: Provider Referral Study, 2005

Provider Perceptions of Clients' Primary Care Needs

Fifty-nine percent of providers asked clients whether they had a primary care provider at their first visit, 45 percent when clients were sick, and 30 percent at every visit. Thirty percent of providers estimated that the majority of their clients needed primary care services in the last year, and 42 percent estimated that the majority of their clients relied on Family PACT as their only source of primary care.

Screening for Insurance Eligibility

The majority (75 percent) of providers screened clients to see if they qualified for other public insurance programs, such as Medi-Cal or Healthy Families. Most providers estimated that a minority of their Family PACT clients were eligible or were unsure whether they were eligible. Specifically, 44 percent estimated that less than one-fifth of their clients qualified for other insurance programs; 19 percent estimated between one-fifth and one-half qualified; 13 percent estimated that more than one-half qualified; and 24 percent were unsure.

Clients' reluctance to disclose their insurance status or to enroll in another program posed barriers to insurance screening (see Figure 3.3.3). Obstetricians/gynecologists (OB/GYNs) expressed the greatest need for information on how to link patients with insurance programs: 43 percent were unsure where to send clients to enroll for insurance, and 36 percent were unfamiliar with the eligibility requirements.

Figure 3.3.3:
Barriers in Screening and Referring Clients to Other Insurance Programs, by Specialty

	General/ internal medicine	Multi-specialty or other	Family planning	OB/ GYN
Clients reluctance to disclose their insurance status	42%	40%	40%	42%
Client resistance to enroll in another program	40%	37%	42%	40%
Concerns about assuring confidentiality provisions	32%	31%	35%	33%
Inadequate information on where to send clients to enroll ***	27%	15%	23%	43%
Unfamiliarity among staff with eligibility requirements ***	22%	17%	28%	36%
Inadequate staff time to provide referrals ***	19%	16%	17%	23%
Staff hesitancy to inquire about clients insurance status ***	10%	9%	4%	13%

* p<0.05, ** p<0.01, *** p<0.001

Source: Provider Referral Study, 2005

Summary

A substantial proportion of providers make referrals to primary care, but there is still room for improvement. DHS-OFP can take several steps to increase the frequency and quality of client referrals to primary care. Different approaches are needed to increase primary care referrals among public and private sector providers and across provider specialties (general/internal medicine, family planning, OB/GYN, and multi-specialty) since the practices and challenges experienced differ among these groups.

Section 4.1: *Services*

Key Findings:

- Use of education and counseling (E&C) services increased from program inception until 2003, when the number of clients receiving E&C services dropped for the first time.

- The majority (about 73 percent) of female clients received a contraceptive method from Family PACT, a proportion that has remained stable over time. However, fewer male clients have been obtaining barrier methods (73 percent in 1999 vs. 58 percent in 2003) and vasectomies (3.9 percent in FY 1997-98 and 0.7 percent in 2003) over time. Findings suggest that there has been an increase in the number of males seeking other program services, such as STI testing and treatment, and E&C.

- Emergency contraception pill (ECP) provision grew markedly after its introduction as a program benefit in November 1999: from one percent of clients in 2000 to 13 percent in 2003. In 2003, White female clients were most likely to be dispensed ECPs and Latinas the least (25 percent vs. eight percent) and adolescents were dispensed ECPs more often than adults (27 percent vs. 10 percent).

- Laboratory services for most STIs increased until 2003, when declines for all STI tests occurred, with the exception of those for Human Papillomavirus (HPV). Utilization of most method-related laboratory tests increased until 2002, and then decreased in 2003.

Introduction

Since 1997, Family PACT has served as an important source for clinical family planning services, contraceptive drug and supply services, and laboratory testing for essential reproductive health care for low-income Californians. An increasing array of family planning options have been made available through the program over time as new Food and Drug Administration (FDA)-approved contraceptive technologies were quickly added to program benefits. Trends in the dispensing of methods and utilization of services have been tracked with Family PACT claims data and are described in this section.

The primary core services in Family PACT are designated by primary diagnosis codes (PDCs) and are categorized according to nine family planning methods/services.[24] Each PDC concerns a specific set of method-related or ancillary services that are covered through the program. At the close of 2003, oral contraception[25] was the most frequently used service among all clients, followed closely by barrier methods/fertility awareness method (FAM).[26] Other services, in order of frequency of use, were contraceptive injection, pregnancy testing, intrauterine contraception (IUC), fertility evaluation, tubal sterilization, contraceptive implant, and vasectomy (see Figure 4.1.1).

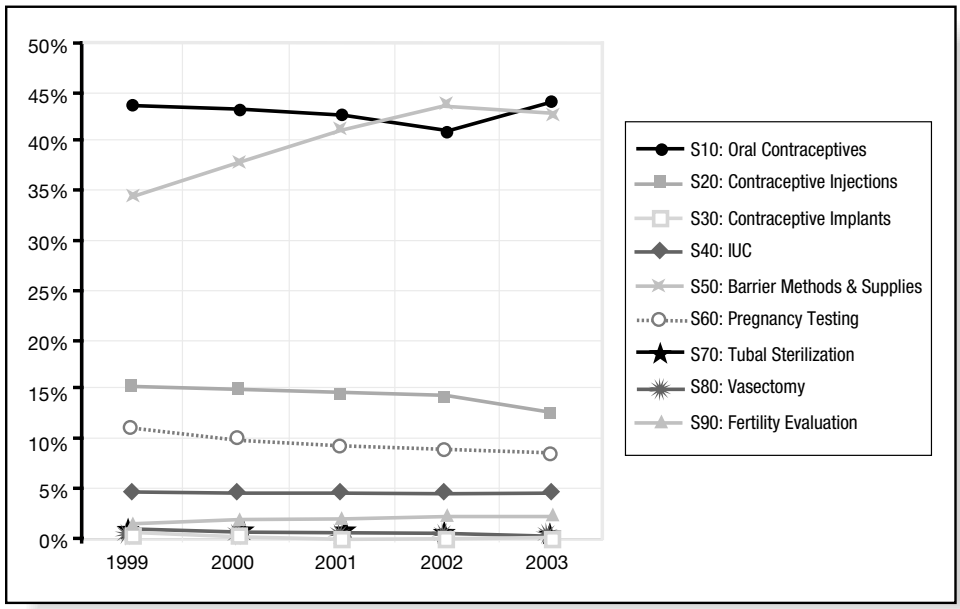
Because PDCs have been exclusive to Family PACT and therefore could not be compared to similar services offered by other programs, the coding scheme will need to be revised in the future in order to comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. New codes will need to be comparable with those used by other programs.

24 PDCs are Family PACT-specific billing codes designated by the letter "S" and are as follows: (S10) Oral contraception/contraceptive patch/contraceptive vaginal ring, (S20) Contraceptive injections, (S30) Contraceptive implants, (S40) Intrauterine contraceptives, (S50) Barriers/fertility awareness method (FAM)/lactation amenorrhea method (LAM), (S60) Pregnancy testing, (S70) Tubal sterilization, (S80) Vasectomy, and (S90) Fertility evaluation. Analyses are based on paid claims data; thus, PDCs reported may not completely reflect the services received by the clients. In other words, some services may have been delivered, but not billed to Family PACT or may have been denied.

25 Ortho Evra® (the contraceptive patch) and NuvaRing® (the contraceptive vaginal ring) became available through Family PACT on Nov. 1, 2002. Both were added to the S10 PDC (oral contraceptive).

26 FAM has been included in the barrier methods code since the beginning of Family PACT, but it is not a common form of contraception among clients. Although the code also includes natural family planning and lactation amenorrhea methods, most clients receiving services under the Barrier Methods/FAM code receive condoms.

Figure 4.1.1:
Trends in the Proportion of Clients Served by PDC, 1999-2003



Source: Family PACT claims data

Clinical Services

Clinical services are the core of the Family PACT Program. Clinicians serve as the point of entry to the program for clients seeking reproductive health services. Clients are screened for eligibility and enrolled in the program at the clinician's office. It is during the clinical encounter that all laboratory and pharmaceutical services are initiated by the clinician. It is where clients are counseled about their reproductive health needs, evaluated for necessary services, and educated about the options available to them. This section describes evaluation findings related to the clinical services provided by the Family PACT Program.

Evaluation and Management (E&M): New and existing clients received E&M services at a level of complexity medically necessary for appropriate care. E&M visits have been coded in four categories according to Current Procedural Terminology (CPT) by presenting problem, complexity, and length, ranging from 10 minutes (Level 1) to 45 minutes (Level 4). Longer visits indicated more severe or complex problems than shorter visits. From FY 1997-98 to 2001, most new patients' E&M visits were coded at the longest duration (Level 4) reimbursed by the program, but in 2002 and 2003, more new patients were seen for a slightly shorter Level 3 visit. Specifically, while 58 percent of new patients were served under the highest level visit code in FY 1997-98, this percentage dropped to 33 percent in 2003. Conversely, while 22 percent of new patients were served under the Level 3 code in 1997-98, this increased to 37 percent in 2003. The reason for this change is not known. A detailed understanding of the substance of an initial family planning office visit at each service level could inform quality improvement efforts and help to establish guidelines for care from the outset of the client-clinician relationship. This topic should be further explored in the 2006-07 Medical Record Review (MRR).

Education and Counseling (E&C): E&C billing codes have been unique to Family PACT and have offered clients, either individually or in groups, guidance on family planning method options, adherence to contraception methods, infertility and preconception care, STI prevention, and choices in pregnancy. As with E&M visit codes, E&C codes are designed to accommodate the complexity of visits – from group education (lowest level E&C) to 45 minute individual counseling (highest level). All E&C visits must have complied with program standards.

The number of clients receiving E&C services grew each year from FY 1997-98 through 2002, ranging from 56 percent growth in 1999 to 9 percent in 2002. Reimbursement for E&C services showed similar trends from 105 percent growth in 1999 to 15 percent in 2002. In 2003, however, the number of clients receiving E&C dropped 3.7 percent from 2002, while reimbursements for E&C decreased 8.6 percent, indicating providers were billing for lower-level visits compared to one year before. The largest declines in E&C services were seen in group education, 45-minute (Level 4) family planning counseling, and extended visits for TSO[27] clients. These reductions may have been due to provider disenrollments as opposed to changes in client needs, and they warrant further exploration through claims data analysis and field assessments.

Sterilization: Though Family PACT covers sterilization services, use of this contraceptive method has been uncommon in the Family PACT population, possibly due in part to the relatively young ages of clients. Other factors that may influence low utilization of this service include provider capability to provide or refer out for this service, low reimbursement rates, billing problems, and/or denied claims.

The percentage of men undergoing a vasectomy procedure declined steadily from 3.9 percent in FY 1997-98 to 0.6 percent in 2002; it slightly increased in 2003 to 0.7 percent. The percentage of women who received tubal sterilization procedures decreased slightly, from 0.5 percent in FY 1997-98 to 0.3 percent in 2003. More Latina clients received tubal sterilizations in each year of the program than clients in all other racial/ethnic groups: in 2003, 0.4 percent of Latina clients had a tubal sterilization, compared to 0.1 percent to 0.2 percent of clients in all other racial/ethnic categories. Given the high efficacy of sterilization and low utilization of these services in the program, further research should explore factors affecting provision rates of this contraceptive option.

Screening Mammography: Mammography became a covered benefit for female Family PACT clients aged 40 and older in 2002. Between 2002 and 2003, slightly more than 12,000 out of 118,000 eligible clients (10 percent) received this service. While this low utilization rate would be expected given the relatively recent introduction of this benefit, providers need to be better informed about the coverage of this service, the importance of screening older female clients, and the need to educate them about mammography. Providers who do not have mammogram facilities on-site would benefit from better referral resources for their patients.

Drug and Supply Services

The majority of clients have benefited from the program's contraceptive services. The proportion of female clients who received a contraceptive method was relatively stable over time: from 1999 to 2003, between 72 percent and 73 percent of female clients were dispensed a contraceptive method annually. However, there was a steady decline in the proportion of male clients receiving a contraceptive method, from 74 percent in 1999 to 58 percent in 2003. This trend suggests that male clients may have enrolled in the program specifically for non-contraceptive services, such as STI testing and treatment, education and counseling, or primary care.[28] Detailed claims data analysis for males who received no contraceptive method was initiated in 2005, but further research on factors that may impact rates of method provision males is also recommended. Provider surveys and MRRs may be evaluation activities well-suited for examining this issue.

27 Eligible Family PACT providers may be reimbursed for expanded counseling under the TSO program, allowing them to bill TSO codes.
28 Primary care is not a Family PACT benefit, but primary care referrals are provided by program clinicians.

Dedicated ECPs: ECPs were first added to Family PACT benefits in November 1999.[29] They have been a growing part of the Family PACT Program, and benefits cover advance provision of this back-up contraceptive method. While only one percent of female clients received ECPs in 2000 (the first full year that ECPs were available), more than 178,000 (13 percent) of female clients received ECPs in 2003. This figure may underestimate actual emergency contraceptive provision because some providers dispense oral contraceptive pills in lieu of a dedicated ECP product.

Since the introduction of ECPs to program benefits in 1999, Latinas have received them less often than women of other racial/ethnic groups (eight percent vs. 15-25 percent in 2003). White women received ECPs most frequently (25 percent in 2003). Adolescent females were dispensed ECPs more often than adults (27 percent vs. 10 percent, respectively, in 2003). Research is needed to identify barriers to and disparities in dispensing ECPs to different racial/ethnic and age groups. For example, adolescents may have greater failure rates in the use of routine contraceptive methods relative to adults, and thus have a greater need for ECPs. The reasons for the large disparity in ECP provision by age can be examined via a special study.

Public providers more frequently dispense ECPs (82 percent in FY 2003-04) than pharmacies[30] (18 percent) or private providers (less than one percent). These large disparities, and the reasons why private clinicians are not often offering ECPs to their clients, could be examined through a provider survey. ECP provision may also have been underestimated if clients did not fill written prescriptions for advance ECP provision. The 2006-07 MRR may quantify the extent of this practice.

IUC: Each year from program inception through 2003, roughly five percent of female clients received services related to IUCs, and one percent of clients received an IUC insertion. By race/ethnicity, Latina clients had the highest rates of IUC insertions (2.0 percent of female clients served in FY 1997-98 and 1.7 percent in 2003) and African-American clients had the lowest rates (0.2 percent of clients served in FY 1997-98 and 0.3 percent in 2003). Asian, Filipino, and Pacific Islander clients had IUC insertions at rates of 1.1 percent in FY 1997-98 and 0.8 percent in 2003; White clients had IUC insertion rates of approximately 0.5 percent in both FY 1997-98 and 2003. IUC insertions were more prevalent among adult clients relative to adolescents; in 2003, two percent of female adults received IUC insertions and 0.4 percent of female adolescents had an IUC insertion. Cultural preferences may have driven some of the differentials by race/ethnicity and should be explored. Hesitancy about using IUCs may also be caused by a lack of awareness of the safety and efficacy of this method, and may be improved with intensified provider and client education. Higher IUC utilization among adults is likely explained by older women's preference for long-term birth control methods after they have completed their desired childbearing.

Hormonal Contraceptives: Among female clients served, differences in hormonal contraceptive use were seen by race/ethnicity and age. In 2003, Latinas received the contraceptive patch more often than women of other racial/ethnic groups (11 percent vs. 7-9 percent). White women received the contraceptive patch the least often (7 percent). Since program inception, White women received oral contraceptives (OC) more frequently than women in other groups (for example, 51 percent vs. 24-40 percent in 2003), while African-American women received oral contraceptives the least often (e.g., 24 percent in 2003). Since FY 1997-98, Asian, Filipino, and Pacific Islander women received contraceptive injections at lower rates than all other women (e.g., 8 percent vs. 10-13 percent in 2003). In 2003, White women received the contraceptive vaginal ring more often than other women (2.1 percent vs. 0.4-1.3 percent). Adolescent females received the contraceptive patch more often than adults (11 percent vs. 9 percent in 2003) and oral contraceptives more often than adults (38 percent vs. 33 percent in 2003). These differences in client preferences will be important to monitor by racial/ethnic group and age as more women begin to use the newer patch and ring technologies.

29 Preven® ECP was added as a benefit in November 1999, and Plan B®, which has a lower potential for adverse side effects than Preven®, was added in February 2001. Preven® was discontinued by its manufacturer in 2004, and thus is no longer available through Family PACT.

30 As of 2001, California law allows specially trained pharmacists to supply ECPs directly to the public without a prescription. The Family PACT Program covers the cost of the medication for a client's direct pharmacy provision of EC, but the client is responsible for the $10 "consultation fee" that most pharmacies charge for this service. There is no consultation fee when a prescription for ECPs is filled at a pharmacy and thus, no added cost to the client.

There was little difference since program inception in the proportion of public versus private providers serving female clients under the oral contraceptive PDC. In FY 1997-98, for example, 50 percent of female clients at public providers and 49 percent at private providers were served under this PDC compared to 53 percent at public providers and 52 percent at private providers in 2003.

Barrier Methods/FAM: Services related to the PDC covering barrier methods/FAM rose for female clients, growing from 31 percent in 1999 to 37 percent in 2002. The proportion stabilized, however, in 2003, at 37 percent. Dispensing patterns for barrier methods showed a similar upward trend: 43 percent of female clients were dispensed barrier methods and supplies[31] in 1999, rising to 48 percent in 2002, and dropping slightly to 47 percent in 2003.

Among men, however, the percentage receiving barrier methods and supplies through the program declined over time: from 73 percent in 1999 to 58 percent in 2003. Given that barrier methods and vasectomy are the only available male-specific contraceptive methods, and that less than one percent of male clients in the program received vasectomies each year, the decrease in barrier method provision among men is an important issue to address. In addition, the potential increase in exposure to STIs due to decreased dispensing of condoms should be investigated.

Both adolescent females and males received barrier methods and supplies more often than their adult counterparts. In 2003, among females, 59 percent of adolescents and 45 percent of adults received barrier methods and supplies; among males, 69 percent of adolescents and 55 percent of adults received them.

Since program inception, a higher proportion of private providers than public providers have served female clients under the barrier method PDC. In 2003, this trend persisted, with 41 percent of private providers and 37 percent of public providers serving female clients under this PDC.

Method Switching among Female Clients: UCSF monitors contraceptive method use by female Family PACT clients through both medical records and claims data. Family PACT medical records review (MRR) data[32] suggest that female clients entering Family PACT switch to more effective contraceptive methods, particularly at their first visit (see Figure 4.1.2). Barrier method users adopted more effective methods at a particularly high rate (29 percent), and oral contraception users were the most likely (of all reversible contraception users) to continue with the same method after their visit (94 percent).

Figure 4.1.2:
Family PACT Contraceptive Method Switching: Efficacy of Contraceptive Method at End of Visit Compared to Method Used Prior to the Visit, by Visit Number

Visit Number	Efficacy of method compared to method at start of visit (N=2,712 visits)					
	Number of visits	More effective	Same method	Less effective	Pregnant/seeking pregnancy	Total
1	447	29%	58%	6%	7%	100%
2	368	14%	78%	4%	3%	100%
3	311	14%	76%	6%	4%	100%
4	262	9%	85%	4%	2%	100%
5+	868	8%	83%	5%	4%	100%

Source: 2002 Family PACT Medical Record Review

Clients who remain Family PACT users were also likely to receive an equally or more effective contraceptive method over time. Table 4.1.3 shows method continuation and method switching among female clients retained from 2002 to 2003. The behavior among users of the three most utilized methods (oral contraceptives, barrier methods only, and contraceptive injections) is examined.

31 Clients are counted as being dispensed a "barrier" method if they had a paid claim for any of the following: condom, diaphragm, cervical cap, basal body thermometer, spermicide, or lubricant.

32 2002 MRR study, Longitudinal Sample. The 2002 MRR provides information on the scope and quality of services delivered during 2000-2001 and identifies changes over time through comparison with the findings from the 1999 MRR. The 2002 MRR includes 4,936 medical records abstracted at 227 provider sites in 13 designated counties. The client sample abstracted from the medical records includes: 1) The General Sample of 3,884 female (89 percent) and male (11 percent) Family PACT clients; 2) The Longitudinal Sample of 544 female clients that received Family PACT services

Figure 4.1.3:
Female Family PACT Clients: Comparison of Select Method Continuation and/or Switching, 2002-03

Primary Contraceptive Method*	Number of women who received the method as their primary method in 2002**	Proportion who returned to Family PACT in 2003 (any paid claim)	Of those who returned in 2003, the proportion that received a method that was **equally or more effective** than primary method received in 2002**		Of those who returned in 2003, the proportion that received a **less effective** method than primary method received in 2002	
			Received the same method	Received a different method***	Received only barrier methods and/or emergency contraception	Received no method
Oral Contraceptives	452,256	61%	70%	13%	7%	11%
Barrier Methods Only	244,182	40%	40%	32%	1%****	27%
Contraceptive Injections	154,034	67%	56%	28%	6%	10%

*Barrier methods and ECPs were not considered "primary methods" unless they were the only method dispensed in the year. For example, if a woman received both contraceptive injections and condoms, she was counted in the "contraceptive injections" category. If a woman received both contraceptive injections and oral contraception (with or without barrier methods and/or ECPs), she was counted as having received "more than one non-barrier primary method."

**Regardless of whether they also received barrier methods and/or ECPs. For this analysis, all hormonal methods were considered equally effective.

***Includes those who received more than one non-barrier, non-ECP method, e.g., oral contraception and IUC in CY 2003.

****Received only ECPs in 2003.

Source: Family PACT claims data 2002-03

Sixty-one percent of oral contraceptive users and 67 percent of contraceptive injection users in 2002 returned to Family PACT in 2003 (well above the average retention rate of 50 percent among female clients). Only 40 percent of barrier-only users returned. Among both OC and contraceptive injection users who returned in 2003, 83 percent of OC users and 84 percent of injection users either continued with their method or switched to one that was equally or more effective. Only 32 percent of barrier-only users that returned in 2003 switched to a more effective method, while 40 percent continued with barrier methods.

Clients were able to receive more than one contraceptive method over the course of a year. Switching methods within a year's time will therefore be important to examine in order to assess method satisfaction and to identify possible problems with method continuation. It may also be beneficial to understand the specific reasons behind switching among various methods. Findings could inform the development of strategies to support switching to and persistent use of more effective methods. Special studies, such as medical records reviews and client exit interviews, are likely the most suited to examining reasons for method switching and discontinuation.

Laboratory Services

Family PACT has provided laboratory services for method-related testing, as well as testing for cervical cancer, STIs, and pregnancy. Cervical cancer screening is discussed in Section 5.3. Other laboratory services are discussed below.

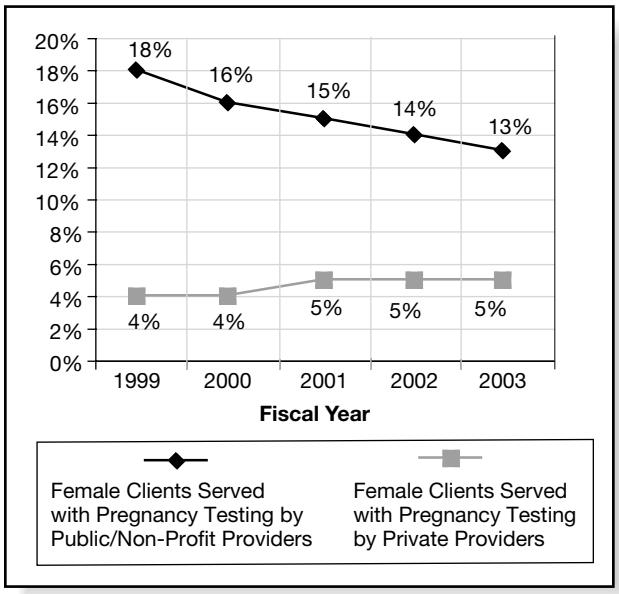
Method-related tests have been used to screen for pre-existing or developing conditions that contraindicate use of a particular method. For example, liver function tests and glucose tests have been used to screen for liver disease and Type 2 diabetes, conditions that may preclude the use of hormonal contraceptives. Method-related testing rates have fluctuated since program inception, with a notable downward trend for tests specific to infertility evaluation for women. In contrast, male clients served with semen analysis testing increased in each year of the program ranging from 40 percent growth in 1999 to 64 percent growth in 2002, though the rate of increase slowed to 5 percent in 2003.

CT and GC tests have been the most widely administered diagnostics in Family PACT each year since FY 1997-98. Female clients receiving these two tests, as well as the test for HPV, increased slightly in 2003, while the number of female clients served with all other STI tests (hepatitis B, human immunodeficiency virus [HIV], herpes simplex virus, and syphilis) decreased. The number of male clients served with STI testing declined for all STI test types in 2003. Reductions in hepatitis B testing were expected due to the elimination of this program benefit on February 15, 2003. Other declines should be monitored to determine whether a correlation exists between enrollment and clients receiving these important diagnostics.

The number of female clients receiving pregnancy tests[33] has grown since program inception, with year-over-year increases of 59.2 percent between FY 1997-98 and 1999, 17.7 percent between 1999 and 2000, 13.0 percent between 2000 and 2001, and 9.5 percent between 2001 and 2002. Growth slowed to only 0.2 percent between 2002 and 2003, a possible result of greater use of more effective forms of contraception, an increased use of in-home pregnancy tests, or billing errors. If future change is inconsistent with recent trends, further investigation of claims data will be indicated.

The data also show opposite trends in pregnancy testing services by public/private provider status. The proportion of female clients served under the pregnancy test PDC increased slightly between 1999 and 2003 among private providers: from four percent to five percent. However, among public/non-profit providers, this proportion decreased over the same period: from 18 percent to 13 percent (see Figure 4.1.4). This decline may have been caused by adjustments to billing practices in accordance with program standards[34], or clinical practices may have changed in ways that are not yet known. In order to qualify for pregnancy-related Medi-Cal services, a woman must have proof of a positive pregnancy test. Thus, some proportion of clients may have used Family PACT pregnancy testing services specifically in order to enroll in Medi-Cal. However, most clients who were served under the pregnancy test PDC in Family PACT also received contraceptive services at some other point that year. The extent to which clients may enroll in Family PACT strictly for pregnancy testing can be evaluated for both adolescent and adult females to shed more light on this area.

Figure 4.1.4:
Trends in Female Clients Served with Pregnancy Testing PDC by Public/Private Provider Type, 1999-2003



Source: Family PACT claims data

Summary

Most female Family PACT clients were dispensed contraceptive methods through program clinicians and pharmacies, but there were disparities in dispensing rates by race/ethnicity and age that should be researched to optimize access to these benefits. A decrease in dispensing of barrier methods to males is significant from both contraceptive and STI-prevention perspectives. Contraceptive method-switching among females has been common, with method continuing greater among women using hormonal methods.

33 These figures refer to actual pregnancy tests, not claim lines billed under the S60 (pregnancy testing only) code.

34 Such as coding pregnancy tests under a different S code when tests are negative or when clients accept some form of contraception; instructions are outlined in the Family PACT billing manual.

Section 4.2: *Reimbursements*

Key Findings:

- Payments for drug and supply services made up the largest percentage of reimbursements (39 percent) as of 2003, with contraceptives accounting for almost one-third of all program reimbursements.

- Reimbursements for laboratory services increased each year through 2002 before decreasing in 2003. Laboratory services accounted for 30 percent of all reimbursements in 2003.

- Reimbursements for clinical services increased each year through 2002 before flattening out in 2003. Clinical services accounted for 31 percent of all reimbursements in 2003.

- Public sector provider reimbursements increased steadily through 2003, while private sector provider reimbursements rose through 2002 and then dropped in 2003, a result of a decline in the number of private sector providers that year.

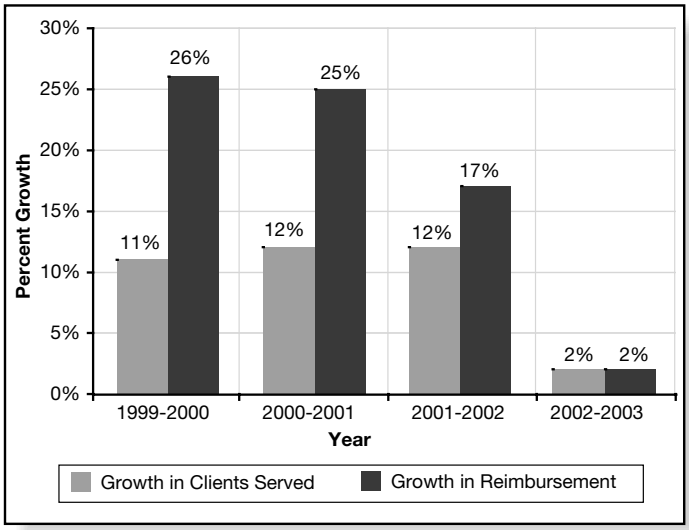
- As of 2003, the highest per-client reimbursement rates in Family PACT were paid for services provided to Latina women ($299) and African-American men ($197); the lowest reimbursement rates were paid for services provided to African-American women ($228) and Asian, Filipino, and Pacific Islander men ($131).

- Between 1999 and 2003, adolescent services composed 18 percent of all reimbursements, while adolescents accounted for 20 percent of all clients during that period.

Reimbursement Trends by Service Category

UCSF tracks reimbursement trends using Family PACT claims data in three broad service categories: clinician services (including mammography), drug and supply services, and laboratory services. Altogether, Family PACT reimbursement grew from $219 million in 1999 to $414 million in 2003, representing year-over-year increases of 26 percent from 1999 to 2000, 25 percent from 2000 to 2001, 17 percent from 2001 to 2002, and two percent from 2002 to 2003. Between 1999 and 2002 growth in the number of clients served was substantially lower than growth in reimbursements, indicating that growth in reimbursement was not completely driven by growth in clients. Growth in clients served played a larger role in reimbursement growth in 2003 when both clients served and reimbursement increased by 2 percent (see Figure 4.2.1).

Figure 4.2.1:
Growth Rates of Clients Served vs. Growth Rates of Reimbursement, 1999-2000 to 2002-2003

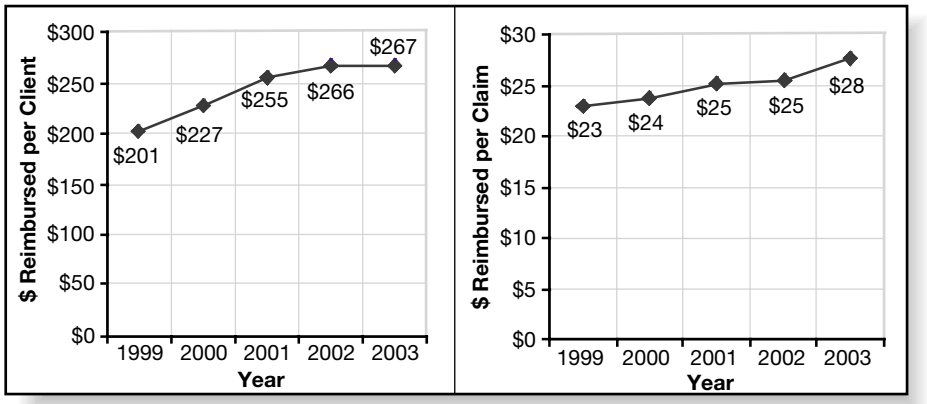


Source: Family PACT claims data

In 2003, growth in reimbursements was driven by increases in payments for drug and supply services, particularly contraceptive drugs. However, in earlier years, growth was more prominent in laboratory services. Contraceptives, including newer hormonal technologies such as the patch, the ring, and emergency contraceptives, accounted for nearly one-third (32 percent) of all Family PACT reimbursement as of FY 2003-04, the most recent period for which this value data is available. Clients were able to obtain prescription drugs covered by the program on-site or at free-standing pharmacies off-site. Reimbursements for all drugs dispensed on-site have been stable over time (about 16 percent of all program services in 2003), but have increased sharply at pharmacies (from 16 percent per year through 2002 to 23 percent in 2003).

As of 2003, drug and supply services made up 39 percent of reimbursement, clinician services 31 percent, and laboratory services 30 percent. The share of reimbursements for both clinician services (from 40 percent to 31 percent) and drug and supply services (from 41 percent to 35 percent) declined every year through 2002, while the share of reimbursements for laboratory services increased sharply (from 19 percent to 34 percent). Since 2002 the share of reimbursements for clinician services has remained flat while the share for laboratory services has decreased and the share for drug and supply services has increased.

Figure 4.2.2:
Family PACT Reimbursement per Client and per Claim by Year, 1999-2003



Source: Family PACT claims data

Reimbursements by Provider Type

UCSF also monitors reimbursements by public and private providers. Changes in program expenditures by provider sector followed trends similar to those seen by service type.[35] Among public providers, steady growth in reimbursements occurred from 1999 through 2003 with growth rates ranging from 9 to 19 percent. Reimbursements among private providers grew at faster rates than for public providers with growth rates ranging from 11 percent to 32 percent. In 2003 the growth in reimbursement among private providers slowed to 11 percent due to a decrease in the number of private providers stemming from disenrollments of two large providers, coupled with slowed provider enrollment. Among private sector providers, reimbursements grew at a faster rate from 1999 through 2002, ranging from a low of 21 percent in 2002 to a high of 32 percent in 2000, before dropping 11 percent in 2003. This decline was due to a decrease in the number of private sector providers in 2003 – including disenrollments of two large providers – coupled with slowed provider enrollment over the same period.

Reimbursements per Client Served

Family PACT reimbursement per client increased from $201 in 1999 to $267 in 2003. However, by 2003 growth had practically stopped, with reimbursement per client rising only $1 from 2002, mostly a result of fewer claim lines per client. The average client had fewer claims billed to the program in 2003 compared to 2002, yet each claim had a higher average reimbursement (see Figure 4.2.2).

Higher average reimbursements do not necessarily imply inefficiency or over-utilization of services. As previously noted, for example, providers have been dispensing newer hormonal contraceptive technologies such as the patch and ring at increasing rates, and these benefits were more expensive than others. At the same time, because these methods require only weekly or monthly changing, as opposed to the daily administration of oral contraceptives, the potential for use effectiveness is higher. A cost-benefit analysis of the various hormonal contraceptives may yield more details in this area and will be conducted during the 2005-2010 evaluation period.

Reimbursements by Sex

Total Family PACT reimbursements for females rose from $213.9 million in 1999 to $384.8 million in 2003. For males, expenditures increased from $5.1 million in 1999 to $35.6 million in 2002, and then decreased to $29.4 million in 2003. Aggregate male expenditures showed a large increase in 2000, which coincides with the program's expansion of male services during that year.

35 Expenditures paid to clinician providers include payments to public and private sector providers for on-site formulary services and on-site laboratory services.

Services to males have accounted for a small percentage of total reimbursements, increasing from 2.4 percent in 1999 to 8.8 percent in 2002, before dropping to 7.1 percent in 2003. This decrease was attributed to the decline in male enrollment. Expenditures for females increased in each year measured.

Reimbursements by Sex and Race/Ethnicity

Among females, per-client reimbursements rose between 1999 and 2003 in all racial/ethnic categories.[36] The greatest growth occurred for Latina clients, increasing from $221 in 1999 to $299 in 2003. In comparison, per-client reimbursements rose over the same period from $192 to $228 for African Americans, from $187 to $259 for Asian, Filipino, and Pacific Islanders, from $206 to $257 for Whites, and from $175 to $233 for other racial/ethnic groups.

Per-client reimbursements for males showed more variation, but have consistently fallen below those for females. Additionally, in each male racial/ethnic group, reimbursements jumped markedly between 1999 and 2000 (with increases ranging from 127 percent for Latinos to 340 percent for Asian, Filipino, and Pacific Islanders), reflecting the expansion of Family PACT services to men at the time. Growth in spending continued to increase through 2002 but at a slower pace (with rates of increase typically well below 100 percent). The slowed growth was less prevalent among Latinos. Per-client reimbursements for males declined sharply in 2003 for Latinos, increased by nine percent for Whites, and were near zero for all other groups. Specifically, services reimbursed for African Americans increased from $55 to $132, from $44 to $104 for Asian, Filipino, and Pacific Islanders, from $66 to $123 for Latinos, from $51 to $116 for Whites, and from $50 to $114 for other racial/ethnic groups. Reimbursements continued to grow through 2003 for African Americans and Whites, reaching $197 and $153, respectively. A reimbursement peak was reached in 2002 for Asian, Filipino, and Pacific Islanders ($137, decreasing to $131 in 2003), Latinos ($183, decreasing to $160), and other racial/ethnic groups ($158, decreasing to $153). The reason for the particularly sharp decline in Latino reimbursements is still being explored; the trend should be watched in future years and compared to provider disenrollments for verification.

While some research on the disparities in service provision by race/ethnicity has already been done (e.g., as described in Section 4.1, Latinas have been dispensed the contraceptive patch more frequently than women in other racial/ethnic categories) it would be useful to monitor trends in utilization by race/ethnicity on an ongoing basis to identify potential policy refinements.

Reimbursements by Age

Total Family PACT expenditures for adolescents increased from $39.8 million in 1999 to $73.4 million in 2003. Expenditures for adults increased from $179.2 million to $340.8 million over the same period. Despite growth in overall reimbursements, the percentage of total expenditures for adolescent clients has remained stable since 1999 at roughly 18 percent each year. In contrast, the percentage of adolescent clients served has been about 20 percent each year.

Summary

Over the five-year period from 1999-2003, yearly total Family PACT reimbursement increased through 2002 before decreasing in 2003. Reimbursements for drug and supply services have risen consistently, while reimbursements for clinician and laboratory services increased through 2002 and then tapered off in 2003. Reimbursements for services to males grew through 2002, but began to decline in 2003. Even at its peak spending for males still made up less than 10 percent of all expenditures.

36 Analysis was limited to the categories of African American, Asian/Filipino/Pacific Islanders, Latina, White, and Other (including Native American). Though Family PACT also classified unidentified race/ethnicity as Unknown, small cell counts prevented analysis for these clients.

Section 5.1: *Adherence to Program Standards*

Key Findings:

- Family PACT Program Standards have set forth the scope, type, and quality of reproductive health and family planning services provided by the program.

- There has been wide variation among providers in complying with standards regarding access to care and clinical and preventive services

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- Expansion of the quality improvement program is needed in the areas of cultural competence, referral documentation, and ease of access to services for populations with special needs.

Development of Family PACT Program Standards

Family PACT Program Standards have guided the delivery of high-quality and accessible family planning and reproductive health care. The standards were developed in the formative stages of the program by the Family PACT Workgroup, which was established to keep the program in compliance with the legislative mandate. The group comprised representatives from stakeholder organizations including the American College of Obstetricians and Gynecologists, the California Academy of Family Physicians, the California Family Health Council, the California Medical Association, the California Primary Care Association, the California Women's and Children's Health Coalition, Planned Parenthood Affiliates of California, and a number of former contractors with DHS-OFP's Clinical Services Contract Program (CSCP).[37]

Adherence to the standards has been required of all Family PACT providers and associated clinicians as part of the formal provider enrollment application and agreement. Compliance with the standards has been monitored and evaluated by UCSF through claims data analyses and special studies, such as the CEI study, the MRR, and the TAS.[38] This section provides a description of the standards, as well as findings from the special studies used to evaluate them.

The Family PACT Program Standards

Seven standards have served both as the program framework and as parameters for expected provider performance, service delivery, and quality improvement:

1. Informed Consent
2. Confidentiality
3. Linguistic and Cultural Competence
4. Access to Care
5. Availability of Covered Services
6. Clinical and Preventive Services
7. Education and Counseling Services

Definitions of and Compliance with Program Standards

Informed Consent: This standard mandates that clients be informed that their consent to services and participation in Family PACT is voluntary, and that they are free to withdraw their consent at any time. Consent is required only from the individual client receiving family planning services, including minors who have the legal right to self-consent. Consent information must be given, both orally and in writing, in a language the client understands. It is accepted medical practice to obtain written consent prior to an invasive procedure, such as the insertion of an intrauterine contraceptive. Data indicate that 78 percent of the female and male clients for whom charts were abstracted (n=3,384) in the 2002 MRR, show that charts containing documented procedures also had documented informed consent. Data from the 2002 MRR indicate that 78 percent of the female and male general sample charts containing documented procedures also had documented informed consent. There is room for improvement in this program requirement; DHS-OFP should generate and distribute guidelines to providers to achieve 100 percent compliance. However, the MRR also found that 100 percent of the charts with sterilization procedures did contain a signed consent form, so non-compliance was limited to non-sterilization cases.

37 The CSCP was the family planning program that preceded Family PACT in California.

38 The CEI is described in Section 2.3. The 2002 MRR is described in Section 4.1. Complete methodologies for these and all other UCSF special studies conducted for the Family PACT Program can be found in the study-specific reports UCSF delivered to DHS-OFP during the evaluation period.

Confidentiality: Confidentiality standards require that all services be provided in a manner that protects clients' privacy and dignity. Assurances of confidentiality are important for increasing all target populations' use of services. The 2001 TAS looked specifically at confidentiality for adolescents.[39] The study found that 90 percent of active providers queried indicated that parental permission was not required for service provision. When stratified by provider sector, virtually no public sector providers required parental permission while 15 percent of private sector providers indicated they did. This disparity should be addressed by DHS-OFP through provider training and technical assistance.

Family PACT allows clients to identify confidentiality concerns as a reason for enrollment, if use of other health coverage for family planning services could create a risk of harm should a parent, spouse, or partner learn that the client sought reproductive health care. Of the total new client enrollments in FY 2000-2001, 55 percent indicated that they were concerned about these risks.

Linguistic and Cultural Competence: This standard requires that clinical services and client materials be provided in a language understood by the client and in a culturally-sensitive manner. Ninety-three percent of clients responding to the CEI study reported that the clinician they saw spoke their preferred language, and 86 percent of providers in the TAS spoke "good" or "very good" Spanish. Assessment of clinician compliance with this standard could be enhanced by developing specific measures for distribution by providers of client educational materials available in as many as nine languages. The Electronic Data Systems (EDS) Warehouse, Inventory, and Distribution Services database is an untapped resource for data collection and analysis. Additionally, an assessment of foreign language proficiency among clinicians may inform the degree to which providers are delivering services in languages understood by clients. UCSF is currently working on a cultural competence assessment that will encompass other elements of cultural awareness, such as program services to males, adolescents, and clients of different races and ethnicities.

Access to Care: This standard addresses mechanisms to reduce barriers to the program in order to increase the number of clients served and assure that they receive timely access to care. Appointments must be scheduled within three weeks of a client's contacting a provider. Findings from the TAS show that, on average, callers were given appointments or walk-in dates that were 5.4 days after the day of the call. Among clients participating in the CEI, 77 percent reported being seen within one week of contacting the provider, and 52 percent were able to access same-day or walk-in appointments.

However, the TAS found that one in five providers (19 percent) identified in the sample (n=430) of randomly selected Family PACT providers listed in the program's automated information and referral service (1-800-942-1054 or 1-866-FAMPACT) had inaccurate phone numbers in the telephone database. Callers were unable to reach 13 percent of providers after obtaining an alternative listing through a referral or directory assistance, and no information was found on 6 percent of providers. Potential clients who have difficulty reaching a provider may forego necessary care. DHS-OFP needs to regularly update and check provider contact information to make sure that the referral line is distributing current information.

The ability to obtain contraceptives and other drugs and supplies at the clinical service site, referred to as "one-stop shopping," prevents an additional trip to a pharmacy and may eliminate a barrier to access. Based on 2003 claims data analysis, 68 percent of clients received drug and supply services at the clinical site, 19 percent at pharmacies, and 12 percent at both sites.

39 The 2001 TAS used "mystery caller" methodology to evaluate access to Family PACT services by examining the telephone interaction between potential new clients and providers. To collect information about services, cost and appointment availability, trained interviewers posing as potential clients telephoned a total of 406 Family PACT providers that included 12 percent of Los Angeles County providers and 22 percent of providers in other regions. Of the 406 providers, 286 were considered "active" providers having billed Family PACT for services in 1999-2000.

Family PACT has not collected information on the specific access issues for persons living with disabilities, such as Telecommunications Device for the Deaf (TDD) or the availability of adaptive medical equipment, such as roll-on scales or adjustable height examination tables. Modifications could be considered for both the CEC form and the program-specific provider application form to collect additional information about client needs in these areas and the availability of such services in provider facilities. Provider education via technical assistance and printed education materials could also help to improve access for clients with disabilities.

Availability of Covered Services: Family PACT requires that all FDA-approved contraceptive methods be available through the program. Based on research by UCSF, and supported by recommendations from the Clinical Practice Committee (CPC), the services and methods covered by the program have been continually updated to ensure access to new methods as they become available. Clients' individual preferences and needs, their comprehensive health histories, and medical findings must be considered during the selection of a contraceptive method.

The TAS showed wide variability in the availability of services. Among providers considered "active," having billed for Family PACT services in FY 99/00 (N=286), 95 percent were able to provide pregnancy tests and 91 percent offered birth control. However, only 39 percent offered emergency contraception within three days, with another 27 percent offering referrals for this service. In addition, only 37 percent provided male condoms, with 11 percent offering referrals. DHS-OFP needs to remedy these deficiencies in access through better provider training and monitoring.

Clinical and Preventive Services: This standard describes the family planning and reproductive health clinical preventive services that must be available to enrolled clients. Examples include screening, testing, and treatment for uncomplicated STIs, cervical cancer screening (discussed in detail in Section 5.3), and male and female sterilization. Additionally, providers are required to obtain a comprehensive health history – updated at least once every two years – that includes a personal, family, sexual, contraceptive history, and an STI risk assessment.

Of the 3,884 charts reviewed in the 2002 MRR, 93 percent had a personal history, 84 percent a family history, 78 percent a contraceptive history and an assessment of previous STIs. For documentation of sexual history only female charts were abstracted (N=2693) for which 71 percent contained documentation of a sexual history within 24 months from the most recently selected Family PACT visit.

Findings from the TAS indicated that 91 percent of providers offered STI services for men or referred patients to other providers for these services; 81 percent were able to perform tubal ligations or refer clients for this procedure; and 46 percent offered vasectomy services, with no providers referring out for this procedure. These findings underscore the need for improvement in all of these service areas.

E&C Services: This standard focuses on promoting optimal reproductive health and clarifying family planning goals for individuals and couples. Services are based on assessments of specific client needs. Providers must also offer unbiased education and counseling about pregnancy options and referral resources based on pregnancy test results. The MRR documented that clients are receiving E&C services on a broad range of topics ranging from psychosocial issues to contraceptive options; however, the MRR did not measure the content and comprehensiveness of the counseling delivered.

Follow-up E&C services tailored to pregnancy tests results are integral to the program. The MRR indicated that nearly 90 percent of clients who had positive pregnancy tests also received options counseling and referrals. According to the CEI, among clients with positive pregnancy tests, E&C was provided most frequently for prenatal care (71 percent), abortion (59 percent), and adoption (31 percent). Among those with negative pregnancy tests, the most common topics of E&C visits were birth control (82 percent), pre-pregnancy care (21 percent), and infertility services (11 percent).

Summary

The seven Family PACT Program Standards provide an effective structure for the delivery, improvement, and evaluation of program services. Provider compliance with the standards is mandatory, but compliance has varied. Most providers have adhered to established practices in informed consent. Providers also demonstrated that they are generally preserving client confidentiality and offering comprehensive clinical and preventive services. However, there has been little consistency in the availability of covered services, especially emergency contraception and male condoms. Also, no data have been collected on program access for people with disabilities; this gap is part of a general need for increased attention to cultural competence within Family PACT.

Section 5.2: *Sexually Transmitted Infection Services*

Key Findings:

- Between FY 1997-98 and 2003, the number of STI tests reimbursed by Family PACT increased more than four-fold, from 716,000 to 2.9 million. The percentage of female clients tested for any STI increased from 49 percent to more than 61 percent. The percentage of male clients tested for any STI grew from more than 33 percent in 1999, when comprehensive STI testing for males became a program benefit, to 70 percent in 2003.

- The proportion of female clients aged 25 and younger screened for chlamydia (CT) rose from 48 percent in FY 1997-98 to 57 percent in 2003.

- Over-screening for CT among women aged 26 and older was also indicated by Family PACT data.

- Providers may have over-screened for gonorrhea (GC). GC screening should be consistent with the 2005 United States Preventive Services Task Force (USPSTF) GC guidelines, which target women aged 25 and younger.

- Almost all chlamydia cases had documented treatment and partner management.

- Providers may have under-reported CT cases to local public health departments; there is a need for improved record keeping for reported cases as well as continued program monitoring of reporting.

- Adherence to program standards for STI care may be improved through developing a standardized risk assessment form, establishing program-wide goals, and monitoring provider-specific testing rates and other STI care practices over time.

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Introduction

Sexually active persons under 25 years seeking care in family planning settings have been an important target population for the provision of STI testing services. CT, which is the most commonly reported STI overall, occurs most frequently in this group. CT is treatable with antibiotics upon diagnosis, but untreated infection can cause infertility in women and epididymitis in men.[viii]

The provision of appropriate screening and diagnostic STI testing services in the Family PACT Program has allowed for the detection and treatment of STIs that might otherwise have resulted in adverse reproductive health outcomes.

This chapter reviews the results of various monitoring and evaluation activities conducted by UCSF in collaboration with the DHS, Sexually Transmitted Disease Control Branch (STD) that focus on Family PACT STI services and provider adherence to national and program standards for STI care. The main areas for evaluation included sexual risk assessment, testing for STIs, treatment and management of cases, including partner management and risk reduction counseling, and reporting of cases for public health surveillance. Specific focus was placed on detection and management of CT cases, since CT has been the largest STI case load in Family PACT. The data sources used for these monitoring and evaluation activities included data from the 2002 Medical Record Review (MRR), paid claims data, the 2004 CEI, and CT and GC prevalence data from a large Family PACT laboratory provider (Quest/Unilab).[40]

Sexual Risk Assessment: This assessment is important for sexually active persons because it provides information that: 1) identifies those at risk for STI/HIV; 2) determines appropriate STI screening; and 3) directs risk reduction counseling. Additionally, sexual risk assessment helps in the selection of an appropriate contraceptive method.

The Family PACT MRR[41] found 71 percent of charts abstracted contained documentation of a sexual history within 24 months from the first abstracted visit date. The CEI was able to assess a broader range of elements included in the sexual risk assessment as reported by the client. Although 93 percent of clients were assessed for at least one element, the proportion of clients assessed for each specific risk factor varied greatly; for example, 21 percent of clients were asked the gender of their sex partner, while 73 percent were asked their number of sexual partners.

40 Since 2003, Quest/Unilab has downloaded and transmitted CT and GC test result data for Family PACT clients to DHS-OFP for program evaluation and prevalence monitoring surveillance. These data have been shared with DHS-STD for analysis by client demographics and provider characteristics, as well as for monitoring of trends over time.

41 2002 MRR study, Female General Cohort

The MRR also found that public sector providers were significantly more likely to document prior STIs (78 percent of females assessed) than private sector providers (63 percent of female clients assessed) ($p<0.010$). Although reasons for the differential are not known, they warrant further examination by DHS-OFP. Of those females assessed for STI history, 12 percent were reported as having an STI in the past 24 months; more females who received services in the public sector had documentation of a previous STI (14 percent) compared to those in the private sector (9 percent). CEI respondents reported past STI diagnoses slightly less frequently, with no statistical significant differences by age or provider type.

These levels of sexual risk assessment among Family PACT providers are consistent with results from a California provider survey conducted by DHS-STD in 2002[ix], but are higher than levels reported in national provider surveys[x] and analyses of administrative claims data. Efforts to improve the level of sexual risk assessment in Family PACT should address barriers providers face in conducting routine assessments.

Trends in the Proportion of Clients Tested for STIs

Comprehensive STI testing and treatment services have been core benefits of the Family PACT Program since 1997 for female clients and since 1999 for male clients.[42] The program uses screening guidelines from both the Centers for Disease Control and Prevention (CDC), as well as DHS-STD, to inform the use of STI tests for screening and diagnosis.

The overall volume of STI tests paid through the Family PACT Program more than quadrupled between FY 1997-98 and 2003: from more than 716,000 to 2.9 million tests. This increase was commensurate with the increase in clients served in the program each year. The proportion of female clients tested for any STI increased from 49 percent in FY 1997-98 to more than 61 percent in 2003; the proportion of male clients tested for any STI increased from more than 33 percent in 1999 to 70 percent in 2003.

CT and GC: The most commonly performed STI tests in Family PACT each year have been for CT and GC. The program standards specify that prevention services for STI/HIV for women and men should be consistent with the CDC guidelines and recognized medical standards. The 2002 CDC Treatment Guidelines specify that CT screening should be performed annually for females aged 25 and younger. Screening for other populations should be based on risk factors. These standards were reinforced through professional education offered to all Family PACT providers as well as through the dissemination of a *Clinical Practice Alert* in June 2003.

Between FY 1997-98 and 2003, the proportion of female clients tested for CT increased from 43 percent to 57 percent. Increases occurred across all age groups and provider sectors. For example, the proportion of clients screened among females aged 25 and younger and among females older than 25 rose from 48 percent and 40 percent, respectively, in FY 1997-98, and to 57 percent for both age groups in 2003. Although there have been no screening guidelines for males, the proportion of male clients tested for CT increased as well, from 40 percent in 2000 to 63 percent in 2003. Reasons for increases in CT testing include dissemination of guidelines by national organizations (e.g., USPSTF, CDC), the California CT Action Coalition and Family PACT. Family PACT provider trainings and teleconferences increased awareness of the importance of screening for asymptomatic CT infections and the use of highly sensitive nucleic acid amplified tests (NAATs), which allow testing without a pelvic examination. NAATs are a proportion of all CT tests increased from 13 percent in FY 1997-98 to 88 percent in FY 2003-04.

MRR data indicate that testing of female clients with chart-documented risk behaviors did not vary by provider sector. Among females from the MRR General Sample tested for CT, 26 percent of client records had documentation of STI signs, symptoms, or contact; this proportion did not vary by age. Among males tested for CT, 34 percent of charts had documented STI signs, symptoms, or contact.

42 STI treatment and HIV testing have been benefits for male clients since 1997.

Conducting screening in populations with at least three percent CT positivity has been shown to be cost-effective.[xi] While the MRR and Quest/Unilab laboratory data both indicated CT positivity exceeding three percent for females aged 25 and younger, positivity among females older than 25 remained well below three percent. This low prevalence of infection indicates that older females were most likely over-screened and may not have been tested solely on risk factors recommended by the CDC and USPSTF.[43] Providers should be advised to screen more women aged 25 and younger and to limit screening among women older than 25 to those with relevant risk factors.

National GC screening guidelines were updated in May 2005 by the USPSTF and recommend annual screening for females aged 25 and younger. However, in light of the consistently low GC prevalence reported in many family planning populations[xii], these guidelines may need further definition of appropriate selective screening criteria. Trends in GC screening in Family PACT show similar patterns to those of CT screening, with little difference by age. Quest/Unilab data for 2003 indicate that GC prevalence was low both overall (less than one percent) and across age groups for female clients (see. Figure 5.2.1). These low prevalence estimates, which are consistent with those reported by the CDC Infertility Prevention Project, suggest over-screening for this infection.

Figure 5.2.1:
CT and GC Positivity among Females by Age, 2003

Age	CT Positivity		GC Positivity	
	Number of Tests	Percent Positive	Number of Tests	Percent Positive
20	19,522	6.3	16,303	0.86
21-25	26,180	4.6	21,617	0.43
26-30	17,467	2.6	15,624	0.29
>30	21,342	1.3	19,765	0.14
Total	**84,511**	**3.7**	**73,309**	**0.42**

Source: Quest Diagnostics

Increases in GC testing occurred over time in Family PACT for both female and male clients, and were the result of expanded use of diagnostic tests that detect both CT and GC in a single specimen. With the consistently low prevalence of GC compared to CT in family planning settings, updated screening guidelines, based on Family PACT estimates of program-wide GC prevalence, are needed to target higher risk female client subgroups and to reduce high levels of GC screening in the program.

The relatively high levels of CT and GC testing among male clients may have resulted from testing either contacts to female CT/GC cases and/or symptomatic male clients seeking care. The expansion of CT/GC testing to males was also facilitated by the ability to use NAATs on urine specimens rather than more invasive specimens. DHS-OFP may want to consider investigating specific reasons for disparities in male and female testing rates via a special study.

CT Re-testing and Repeat Infection: The 2002 CDC Treatment Guidelines recommend re-testing of CT cases within three to four months after the initial infection. Information from CT cases identified in the MRR and the Quest/Unilab data were used to evaluate re-testing of CT cases and repeat infection among those re-tested. Based on linkage of the Quest/Unilab data to the paid Family PACT claims data, 36 percent of CT cases were re-tested within six months. Female clients aged 25 years and younger were more likely to be re-tested than female clients over age 25 years. Of those re-tested for CT, approximately 10 percent had a repeat infection, a finding consistent with other studies of repeat infection based on observational data.

The major limitation of using observational data is that only those who return to the clinic are evaluated in the analyses. It is more likely that those with symptoms, and those more likely to be re-infected, will return to the clinic for re-testing. Further efforts should facilitate re-screening among CT cases to identify and treat repeat infection. Strategies needing further evaluation include giving clients a reminder card, having them make a re-test appointment at the time of their initial diagnosis, and encouraging use of self-collected vaginal swab specimens.

43 These include multiple or new partners, past STD history, and inconsistent condom use.

HIV: HIV testing has been the third most common STI test since the inception of Family PACT. The proportion of female clients who received HIV testing increased from seven percent in FY 1997-98 to nearly 25 percent in 2003. The proportion of male clients who were tested for HIV increased from 33 percent in 1999 to 50 percent by 2003.

These proportions likely underestimate the true level of HIV testing among Family PACT clients. Only "confidential" HIV tests were reimbursed through the program, while "anonymous" tests were covered through Office of AIDS (Aquired Immune Deficiency Syndrome) program funding.[44]

Syphilis: Syphilis testing levels were similar to those of HIV. The proportion of female clients who received syphilis tests rose from 8 percent in FY 1997-98 to more than 23 percent in 2003; and the proportion of male clients who received syphilis tests rose from 38 percent in 2000 to 50 percent in 2003. Given the low incidence of infectious syphilis in California, much of this testing most likely occurred during baseline assessments of clients entering the program without previously documented serologic results. Higher syphilis testing among males may reflect the higher prevalence of bacterial STIs found among partners of STI cases who may also have been exposed to multiple STIs and therefore required multiple STI tests. However, the consistently low percentage (less than one percent) of all syphilis tests that were associated with a confirmatory result in all years suggests that infectious syphilis is infrequent in Family PACT, which is consistent with the epidemiology of syphilis in California during the same period.

Hepatitis B: Serologic testing for various antibodies to hepatitis B was a covered benefit in Family PACT from 1997 until February 2003. Approximately seven percent of all female clients received hepatitis B tests in 1997, increasing to 20 percent in 2002. A higher proportion of male clients were tested for hepatitis B antibodies, with 27 percent tested in 2000 and 47 percent in 2002. DHS-OFP, in consultation with the Family PACT Clinical Practice Committee, determined that serologic testing was not a cost-effective strategy for identifying candidates for hepatitis B vaccination in such a low risk population, and instead retained reimbursement for hepatitis B vaccination if immunization status was unknown.

Herpes: Testing for genital herpes using culture and stains was primarily intended to identify and manage ulcers and lesions associated with herpes simplex virus type 2 (HSV-2). HSV-2 testing has been relatively infrequent, and accounted for less than one percent of all STI testing since program inception.

HPV: Testing for HPV became available as a benefit in 2000, but only as a reflex test to determine management of an atypical squamous cell-unspecified significance (ASCUS) Pap smear result. Utilization was therefore related to the occurrence of this outcome among female clients and laboratory adoption of the test. Since HPV testing was introduced, the proportion of female clients receiving this test rose from 0.6 percent of all STI tests in 2000 to 1.6 percent in 2003, reflecting the increase in laboratories capable of performing the test.

Treatment Compliance

MRR data for CT cases demonstrated that appropriate and timely management of CT infection was common, but not universal, among Family PACT providers: nearly 93 percent of all CT cases had documented treatment, and 84 percent received treatment within 14 days of the CT test date. However, there were differences by client sex: 88 percent of females and 97 percent of males had documented treatment; 73 percent of females versus 96 percent of males received treatment within 14 days. There were no significant differences by age or provider sector for treatment within 14 days of the CT test date.

Ensuring timely treatment can prevent transmission to partners and development of upper genital tract infections. Further development of partnerships with local public health departments for disease intervention specialist follow-up may also enhance timely treatment of patients and partners identified in family planning settings.

44 Anonymous HIV testing uses code numbers or code names to identify tests instead of actual names/identifiers of a patient. Confidential testing is linked to patient names/identifiers.

Partner Management

Documentation of partner management was defined in the MRR as any indication of partner management practices, including partner self-referral and contact testing and/or treatment of partners for female CT cases, including patient delivered partner therapy. Overall, 87 percent of female CT cases had documented partner management. Although public sector providers were more likely to document partner management for female CT cases compared to private sector providers (87 percent vs. 71 percent), this difference was not statistically significant. Overall, this level of performance was higher than that observed in other assessments of providers.[xiii]

Risk Reduction Counseling

Evaluation of STI/HIV risk reduction counseling was based on MRR data. Forty-five percent of charts contained documentation of education and counseling on STI/HIV prevention, which was lower than the 49 percent found in the FY 1997-98 MRR. There were no statistically significant differences in STI/HIV prevention-specific education and counseling services by provider sector. Forty three percent of female clients who had been tested for CT had documented STI/HIV counseling, with younger females (aged 25 years and younger) more likely to be counseled (47.7 percent) than older females ($p < 0.05$). In addition, public sector providers were significantly more likely to document STI/HIV counseling for CT positive females compared to private providers (74 percent vs. 56 percent [$p<0.05$]).

While other provider studies[xiv] indicate that provision of STI/HIV risk reduction counseling is infrequent, providers who participate in a program of integrated family planning and STI services may be more likely to incorporate counseling and "teaching moments," since they have a broader perspective on their clients' reproductive health needs.

Reporting of Cases to Public Health Surveillance

Reporting of selected STIs by laboratories and clinical providers is mandated by the California Title 17 regulations governing STD surveillance and control. Reporting was evaluated using 2002 MRR data to measure the proportion of positive CT tests with documented reporting to the local health jurisdiction and was defined as presence of the confidential morbidity report (CMR) and/or documentation of reporting the case. Overall, 62 percent of all CT cases had documented reporting to the local health jurisdiction. There were no statistically significant differences by client age or by provider sector. This analysis may indicate under-reporting of CT, and possibly other, reportable STIs, to local health departments. Under-reporting may due in part to an assumption that the laboratory-generated CMR may be sufficient for reporting, even though a provider report is also mandated. It is recommended that DHS-OFP identify strategies to facilitate provider reporting of STIs and improve documentation of reporting until the DHS web-based CMR communicable disease system reporting system is implemented.

Summary

STI test volume in Family PACT has increased significantly during the evaluation period. Male clients were more likely to receive diagnostic tests for a wider spectrum of STIs than female clients, who tended to be screened primarly for asymptomatic CT and GC infections.

Section 5.3: *Cervical Cancer Screening*

Key Findings:

- UCSF calculated that annual cervical cancer screening in Family PACT averted 9,555 lifetime cases of cervical cancer, with most averted cases occurring among women younger than 30 years old.
- Between 1999 and 2003, cervical cancer screening rates decreased from 48 percent to 39 percent for clients aged 19 and younger, consistent with program screening guidelines.
- Slightly more than half (53.6 percent) of female Family PACT clients received a Pap smear in 2003.
- In 2003, Latina women had the highest screening rates in the program (56.1 percent), and African-American women had the lowest rates (46.0 percent).
- There is substantial room for improvement in providing appropriate follow-up to patients with abnormal Pap results; provider training is indicated.

Background

Cervical cancer is caused by HPVs, which are generally transmitted through sexual contact.[xv] Incidence of localized (confined to the cervix) invasive cervical cancer is highest among women aged 40-49, and incidence of advanced invasive cervical cancer is highest among women aged 60-69. At almost every age, incidence is higher among Latina women than non-Latina women. In the U.S. in 2005, 10,370 cases of cervical cancer were newly diagnosed and about 3,710 deaths from the disease were predicted to occur.[xvi]

Because cervical cancer is preventable, and because it is more easily and successfully treated when diagnosed at an early stage, early testing and treatment guidelines have been promoted by UCSF for use in Family PACT. Pap screenings, reflex HPV testing, dysplasia evaluation, and dysplasia treatment have been program benefits, and UCSF has closely monitored the utilization of these services over time using Family PACT claims data. In addition, UCSF has conducted special evaluations of cervical cancer screening in Family PACT. These studies estimated averted cases of the disease using billing data and cervical cancer prevalence data from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), and examined disparities in screening using laboratory data, client records, and MRR data.

Cervical Cancer Screening Guidelines

Historically, national recommendations have called for annual cervical cancer screenings. However, current nationally recognized clinical practice guidelines suggest that screenings be performed less frequently. In June 2005, the Family PACT CPC Committee adopted the American Cancer Society (ACS) "Guideline for the Early Detection of Cervical Neoplasia and Cancer"[xvii] as the policy of the Family PACT Program. The ACS specifies that women younger than 30 years of age should begin having Pap smears either three years after first intercourse or at age 21, whichever comes first. After an initial, normal screening, biennial Pap smears with liquid-based Pap technology[45] or annual Pap smears with conventional cytology are recommended for women younger than 30, and every two or three years for women aged 30 and older.

Combined Pap smear and HPV screenings (co-screening) have been recommended for women aged 30 and older in order to improve the accuracy of Pap screening and to reduce the screening interval to every three years for women who screen negative for both tests. However, there is little evidence to support co-screening in well-screened, healthy women with a history of normal Pap smears. In addition, in order for this strategy to be effective, women who screen Pap negative and HPV negative should not be re-screened any more frequently than every three years. Because Family PACT has not had access to individual client lab results, it has not been possible to monitor a co-screening benefit that could be limited to those clients with previous and/or current abnormal Pap results.

Use of Cervical Cancer Testing and Related Services in Family PACT

Pap smear results determine what follow-up testing and treatment are appropriate for each client. Normal Pap results indicate future testing in one to two years for clients under 30 or those with health conditions warranting more frequent testing, and in two or three years for older clients.

45 More than 90 percent of Pap smear claims in Family PACT utilize liquid-based cytology.

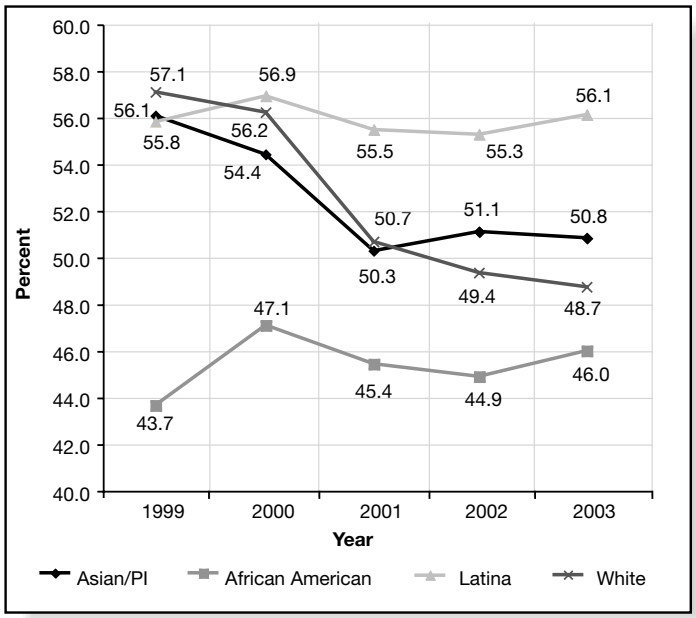
Abnormal Pap smear results indicate dysplasia (atypical cells on the surface of the cervix), and trigger one of several courses of action depending on the severity of the abnormality. Some findings such as ASC-US or low grade squamous intraepithelial lesion (LGSIL) indicates the need for re-testing in four to six months. Other results, such as high grade squamous intraepithelial lesion (HGSIL), will necessitate a colposcopy (an examination of the cervix), which may or may not be followed by cryotherapy (destroying the dysplasia by freezing it) or a Loop Electrosurgical Excision Procedure (LEEP). Other treatments for dysplasia, such as cervical cone biopsy and laser therapy, are not covered benefits in Family PACT.

Trends in Cervical Cancer Screening by Race/Ethnicity in Family PACT

Pap screening decreased slightly over time, with tests administered to 55.2 percent of all female Family PACT clients in 1999, and to 53.6 percent in 2003. When stratified by race/ethnicity, screening rates show fluctuation and variation. Rates dropped from 56.1 percent among Asian, Filipino, and Pacific Islander females in 1999 to 50.8 percent in 2003, and from 57.1 percent among White females in 1999 to 48.7 percent in 2003. Rates increased from 43.7 percent among African-American females in 1999 to 46.0 percent in 2003, and from 55.8 percent among Latina females in 1999 to 56.1 percent in 2003 (see Figure 5.3.1).

The reasons for the disparities in Pap smear rates by race/ethnicity are not known and should be investigated. While it is encouraging that – given the higher cervical cancer incidence among Latina women in the United States – Latina women have the highest screening rates in Family PACT, only slightly more than half of eligible female clients received this important diagnostic test. The decreased rates among Asian, Filipino, and Pacific

Figure 5.3.1:
Pap Screening Per Year by Race/Ethnicity, 1999-2003



Source: Family PACT Claims Data

Islanders and Whites, and the historically low rates among African Americans, also need to be addressed. It is not possible to determine from these figures if cervical cancer screening was in fact underutilized in the aggregate female Family PACT population or in segments of it. For example, decreasing testing rates could have been the result of normal initial screenings in earlier years that reduced the number of necessary annual follow-up tests according to current guidelines. Client attrition may also have been partially responsible for changes in rates. New clients may have been tested elsewhere shortly before enrolling in Family PACT and so did not need to be screened again right away. It is recommended that DHS-OFP monitor testing patterns on a per-client basis over time to ascertain whether or not proper utilization of cervical cancer screening is occurring.

Trends in Dysplasia Evaluation and Treatment by Race/Ethnicity

UCSF also documented women receiving diagnostic evaluation or treatment for dysplasia stratified by race/ethnicity. Over the period from 1999 to 2003, both diagnostic and treatment rates rose for Asian, Filipino, and Pacific Islanders (from 1.84 percent to 2.50 percent for diagnostics and from 0.31 percent to 0.42 percent for treatment), Latinas (from 1.70 percent to 2.26 percent for diagnostics and from 0.36 percent to 0.45 percent for treatment), and Whites (from 2.26 percent to 3.17 percent for diagnostics and from 0.41 percent to 0.44 percent for treatment). Treatment rates in 2003 were slightly lower than in 2002 among Asian, Filipino, and Pacific Islanders and Latinas, and diagnostic and treatment rates dropped from 1999 to 2000 among Whites before increasing later in the period. Among African Americans, diagnostic rates rose from 1.62 percent to 2.22 percent, but treatment rates fluctuated over the period, beginning at 0.30 percent in 1999, and ranging from a low of 0.26 percent in 2000 to a high of 0.33 percent in 2001. After this peak, rates decreased to 0.31 percent in 2002 and to 0.27 percent in 2003.

Trends in Cervical Cancer Screening by Age Group

UCSF calculated Pap screening rates for clients in three age groups: Aged 19 and under, aged 20-29, and aged 30 and over. Over the period from 1999 to 2003, rates decreased from 47.8 percent to 39.1 percent for clients aged 19 and under, a reduction that is consistent with current screening guidelines. Among clients aged 20-29, rates rose from 56.2 percent in 1999 to 56.6 percent in 2000, and then dropped to 54.1 percent by the end of the period in 2003. An increase in testing rates in this age group should have manifested if providers were consistently following screening guidelines. Women aged 30 and over experienced changing rates, from 58.7 percent in 1999 to 61.3 percent in 2000, 59.6 percent in 2001, 60.1 percent in 2002, and 61.7 percent in 2003. Given recommendations to have two- or three-year screening intervals for healthy women in this age group, the fluctuation is not implausible. However, it will be important to follow client-level testing patterns to confirm that compliance with guidelines is driving the changing rates. The next UCSF MRR study, if it includes a longitudinal cohort of Family PACT clients, may be an appropriate tool with which to examine client-level Pap screening and follow-up.

HPV Testing

HPV tests were added to Family PACT benefits in July 2000, and cover only reflex testing of Pap smears that show ASC-US results. In 2001 (the first full calendar year of available HPV test data), 0.6 percent of female Family PACT clients received an HPV test, in 2002, 1.3 percent had the test, and in 2003, 1.6 percent were tested.

While UCSF has monitored trends as described above, further research is needed to identify relationships between Pap smear results and the various follow-up testing and treatments. For instance, future ongoing monitoring can include linking a client to all associated cervical cancer events over time to identify patterns in care and interventions to improve service provision and client access to program benefits. Two UCSF studies look at additional aspects of cervical cancer screening in Family PACT: first, an estimate of averted cervical cancer cases due to screening; and second, a retrospective analysis of follow-up for clients receiving Pap smears. These studies are described below.

Estimates of Averted Cervical Cancer Cases in Family PACT

UCSF analyzed program billing data from FY 2001-02 in conjunction with cervical cancer prevalence data from the NBCCEDP to estimate the number of cervical cancer cases prevented by Family PACT screening services. Using NBCCEDP prevalence data was necessary because colposcopy results were not available for women in Family PACT. The NBCCEDP population is demographically and socioeconomically similar to the female Family PACT client base.

Researchers developed a mathematical model based upon the 618,261 program clients who had Pap smears in FY 2001-02 and the NBCCEDP data. Annual screening until women turn 55 was found to avert approximately 9,555 lifetime cases of cervical cancer, when compared to women who were never screened. The majority (85.8 percent) of averted lifetime cases were seen in women screened before they turned 30, emphasizing the importance of performing Pap smears early and often in a woman's sexually active lifetime. Family PACT guidelines are consistent with these findings and should be stressed to providers to encourage annual screening in younger women.

Evaluation of Cervical Cancer Screening in Family PACT

UCSF also conducted an evaluation of cervical cancer screening follow-up using laboratory data linked to Family PACT client records in 1999, and using findings from the 2000-2001 MRR. The goals of this study were to identify client groups receiving less than optimal disease management and provider-level patterns in care provision, and to document areas in which quality assurance could be improved through provider training.

The laboratory data indicated that 85 percent of the 81,098 Pap tests conducted in 1999 were within normal limits. Among atypical glandular cells of undetermined significance (AGUS)/HGSIL results, where colposcopy was the appropriate follow-up, 58 percent of clients received the proper course of action; where colposcopy and cryotherapy or LEEP were indicated, 63 percent of clients were properly served. These numbers are low and suggest that researching why higher numbers of women with abnormal Pap results are not adequately served should be a priority. Client attrition may be one cause, but the extent of this factor is not known. Some providers may also be referring clients with abnormal Pap results to other clinicians for follow-up, and not billing Family PACT for these services.

More Asian, Filipino, and Pacific Islanders (70 percent) and Whites (70 percent) received correct follow-up than Latinas (54 percent) and African Americans (55 percent). A Chi-square analysis shows significant differences by race/ethnicity ($p<0.0001$). The cell count in the Asian, Filipino, and Pacific Islander category was low (n=27), so this finding may not be generalizable beyond the sample. Fewer adolescents (roughly 50 percent) received correct follow up than adults (about 60 percent; $p=0.016$).

MRR data on 836 women receiving Pap smears during the first six months of FY 2000-2001 showed that 88 percent of the tests were normal. Fifty percent of the AGUS and 88 percent of the HGSIL results were followed up correctly, indicating the need for substantial improvement in provider practices. A study to identify barriers to appropriate follow-up would be a good first step.

Summary

Cervical cancer is preventable when pre-invasive lesions are identified and treated, and Family PACT has established policies and guidelines that allow providers to assess the cervical health status of every female client. UCSF research has also documented the high numbers of averted lifetime cervical cancer cases attributed to annual screening of women under age 30. However, provider adherence to best practices is weak and warrants prompt and thoughtful attention by DHS-OFP.

Section 5.4: *Fertility and Birth Trends*

Key Findings:

- California's adolescent fertility rate dropped below the national adolescent fertility rate after the implementation of Family PACT in FY 1997-98. In 2002, the fertility rate was 41.1 births per thousand women aged 15-19 in California vs. 43.0 for the U.S..
- Reductions in both adolescent fertility and in births to women living in geographic areas of high unmet need exceeded the goals of the waiver from 2000 to 2003.
- The population of female adolescents (aged 15-19) is expected to increase 10.6 percent between 2004 and 2008 indicating the need for continued family planning service provision and outreach to this target population.

One of the Family PACT Program's overarching goals has been to reduce the rate and overall number of unintended pregnancies. An examination of fertility and birth trends in California lends some insight into the program's success in achieving this goal. This section uses national and state vital statistics and state fertility projections to describe demographics related to fertility patterns in California, and fertility and births over the past several years both in the state and among Family PACT clients.

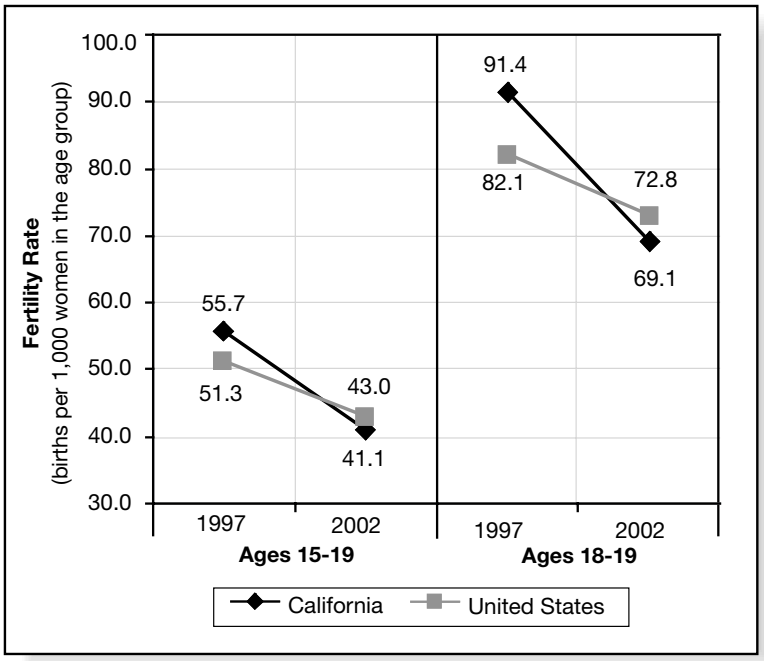
The median age for women in California in 2000 was 34.4 years, while the median age for U.S. women was a slightly older 36.5 years.[xviii] The general fertility rate (GFR) is defined as births to women aged 15-44 per 1,000 women aged 15-44. In 2002, the California GFR was 68.3, above the national rate of 64.8. The GFR decreased in California from 1999 to 2002 (from 69.0 to 68.3), but increased in the U.S. (from 64.4 to 64.8).[xix]

The birth rate measures live births per 1,000 people in the total population. Birth rates, including those to adolescents, are higher in the U.S. than in almost all other industrialized countries in the world.[xx] In California, birth rates are substantially higher among certain sub-populations, such as adolescents, foreign-born residents, and low-income women.

Births to Adolescents

UCSF analyzed state and national fertility rates among adolescents over several years of Family PACT activity. Between 1997 and 2002,[46] California's adolescent fertility rate (live births per 1,000 females aged 15-19) fell below the national rate. The state experienced a 26.2 percent reduction in the adolescent fertility rate from 1997-2002, with births per 1,000 adolescent females falling from 55.7 to 41.1. In comparison, the U.S. as a whole saw a drop of 16.2 percent in adolescent fertility, decreasing from 51.3 in 1997 to 43.0 in 2002.[xxi] Differences over time were also striking among females aged 18 and 19. In this subgroup, the fertility rate in California dropped from 91.4 in 1997 to 69.1 in 2002, a 24.4 percent reduction. In contrast, at the national level, fertility rates for this population decreased 11.3 percent, from 82.1 in 1997 to 72.8 in 2002 (see Figure 5.4.1).[xxii]

Figure 5.4.1:
Trends in Adolescent Fertility Rates in California and the U.S., 1997-2002



Sources: U.S. Census 2004; Hamilton BE, et al., 2003, op. cit.; Martin JA, et al., 2003, op. cit.

46 2002 is the most recent year for which final US birth data are available.

Births to Low-Income Women

Low-income women are defined in Family PACT as those women living in households with incomes at or below 200 percent of the FPL. In 2004, 37 percent of women aged 20-44 were at or below 200 percent of the FPL,[xxiii] and over the period from 2000-2004, 39 percent of women aged 18-44 were at or below 200 percent of the FPL.[xxiv] Between 2000 and 2004, among women who gave birth to a live baby in the 12 months prior to a survey of California women, 52.58 percent were at or below 200 percent of the FPL.[xxv] Also, in 2001, nearly 43 percent of all deliveries in California were funded by Medi-Cal.[xxvi] While some low-income women receive family planning and reproductive health care services through the Medi-Cal Program, many of them do not qualify for this coverage and therefore face significant financial barriers to accessing necessary care. Family PACT helps to fill this essential gap in services.

Progress in Meeting California's Family PACT Waiver Objectives

Reduction of Adolescent Fertility Rates Was Greater Than Projected: A key objective of the waiver was to reduce the adolescent fertility rate in California by an average of at least two percent of the projected fertility rate beginning in the third year of the demonstration period.[47] This objective was exceeded in every year of the waiver. Statewide, actual adolescent fertility rates were 17.4 percent lower than projected for 1999, 20.8 percent lower for 2000, 26.3 percent lower for 2001, 32.2 percent lower for 2002, and 35.8 percent lower for 2003 (see Figure 5.4.2, below).

Figure 5.4.2:
Trends in Projected and Actual Fertility Rates for California Adolescents, Aged 15-19, 1999-2003

Adolescent Fertility Rates	1999	2000	2001	2002	2003
Adolescents 15-19 Projected in 1996	59.8	59.9	60.2	60.7	61.4
Adolescents 15-19 Actual	49.4	47.4	44.3	41.2	39.4
% Adolescents Actual Lower than Projected	**-17.4%**	**-20.8%**	**-26.3%**	**-32.2%**	**-35.8%**

Sources: Statewide Projected in 1996: CA Dept of Finance, Demographics Research Unit. Historical and Projected Births, 1970-2006; Statewide Actual: California Department of Finance, Demographics Research Unit. Historical Births through 2003.

In absolute numbers, female adolescents in California have had 85,500 fewer births than projected since the beginning of the waiver,[xxvii] despite a ten percent increase in the number of adolescent females (from 1.1 million in 1999 to 1.2 million in 2003).[xviii]

Births in the 14 Targeted Counties[48] of High Unmet Need Were Lower than Projected: Another waiver objective was to reduce births in the 14 counties targeted as areas of high unmet need (see Section 2.1) by an average of two percent more than the projected fertility rate for these areas, beginning in the third year of the demonstration period. As with the success seen in reducing adolescent fertility, this objective was met in each year of the waiver. Births were 4.4 percent lower than projected in 1999, 3.4 percent lower in 2000, 4.8 percent lower in 2001, 5.2 percent lower in 2002, and 4.6 percent lower in 2003.[49] These percentages translate into an absolute decrease of 38,068 births to this target population over the period from 1999-2003. In addition:

- Six of the 14 counties had actual numbers of births at least five percent lower than projected in 2003.
- In the same year, the six target counties with the largest populations (Fresno, Orange, Riverside, Sacramento, San Bernardino, and Ventura), five had actual birth numbers lower than projected, while the number of births in the remaining county, Sacramento, was above its projection. The number of births in the two largest counties, San Bernardino and Orange, were each lower than projected by 8.3 percent.
- Orange County, which had the largest number of projected births (between approximately 45,000 and 50,000 births per year), has made the most dramatic progress. In 1999, the number of births in Orange County was two percent lower than projected, and has continued to decline to more than eight percent lower in 2003 than projected at the beginning of the demonstration project.

47 In 1996, adolescent pregnancy projections were made for the 5 years of the waiver. The waiver agreement states that "Beginning in the third year of the demonstration period (CY 2002), births to adolescents eligible for Family PACT will be reduced by an average of two percent more than the projected birthrate for this population during the demonstration period."

48 Alpine, Fresno, Imperial, Mariposa, Orange, Placer, Riverside, Sacramento, San Bernardino, Sierra, Solano, Ventura, Yolo, and Yuba Counties.

49 Age-specific population projections from 1996 — necessary for the denominator for the fertility rate — were unavailable at the county level.

Fertility Rates for Women Aged 15-44 Were Lower than Projected: Statewide, the general fertility rate was 6.7 percent lower than projected for 1999, 5.0 percent lower for 2000, 7.0 percent lower for 2001, 7.8 percent lower for 2002, and 7.3 percent lower for 2003 (see Figure 5.4.3).

Figure 5.4.3:
Trends in Projected and Actual Fertility Rates for California Women Aged 15-44, 1999-2003

General Fertility Rates	1999	2000	2001	2002	2003
Statewide Projected in 1996	73.6	73.7	73.8	74.2	74.9
Statewide Actual	68.6	70.0	68.7	68.4	69.5
% State Actual Lower than Projected	**-6.7%**	**-5.0%**	**-7.0%**	**-7.8%**	**-7.3%**

Sources: Statewide Projected in 1996: California Deparemtent of Finance, Demographics Research Unit. Historical and Projected Births, 1970-2006; Statewide Actual: California Department of Finance, Demographics Research Unit. Historical Births through 2003.

Summary

The rapid decrease in fertility among adolescents statewide and among all women in targeted, underserved counties illustrates the success that the Family PACT Program has had in achieving its objectives. Despite this progress, the need for Family PACT services among adolescents is growing for three key reasons. First, the adolescent fertility rate is still high. The rate in some California counties is nearly twice as high as the overall statewide rate and between four and 12 times higher than adolescent fertility rates in France, Spain, Italy, the Netherlands and Japan.[xxix] Second, California is experiencing a period of rapid growth in the number of adolescents, in which the number of 10- to 19-year-olds has been forecasted to increase 34 percent between 1995-2005, compared to an overall U.S. increase in this age group of 13 percent.[xxx] The adolescent female population (aged 15-19) will increase 10.6 percent between 2004 and 2008.[xxxi] As a result, the California Department of Finance predicts that the annual number of births to adolescents will rise by 23 percent between 2001 and 2008 due to population growth alone.[xxxii] Third, two-thirds of births to adolescents (and 31 percent of all births in the U.S.) are unintended.[xxxiii]

Section 5.5: *Meeting the Need for Family Planning Services*

Key Findings:

- Between 2000 and 2010, a shift in the population composition of reproductive aged women 13-44 is projected to result in a 3.7 percent rise in females aged 13-24 and a 3.1 percent decrease among women aged 25-44, indicating that more women with more years of childbearing ahead of them will be in the California population by the end of the decade.

- There was a steady increase in need met by Family PACT for all women aged 13-44 between 1999 and 2003, from 41.1 percent to 57.3 percent.

- The largest growth in need for publicly-funded family planning services met by Family PACT occurred among women in the 20-24 age group, with need met by Family PACT rising from 51.4 percent in 1999 to 84.1 percent (more than 8 out of 10 women) in 2003.

Defining Unmet Need

California residents eligible for participation in the Family PACT Program are identified as being in need of publicly-funded family planning services if they are at risk of becoming pregnant or causing a pregnancy, and they have household incomes at or below 200 percent of the FPL. Low-income women are particularly unlikely to have the out-of-pocket resources to pay for family planning services and supplies and are at higher risk for unintended pregnancy relative to women with greater financial means. Identifying women with high unmet need and where they live allows DHS-OFP to target outreach specifically to this population niche. Performing this analysis over time permits DHS-OFP to measure progress in meeting the family planning needs of low-income females.

This section draws on analyses of Family PACT claims data, state population projections, and state and national health survey data to present the proportion of women in need of publicly-funded family planning whose needs were met through Family PACT services alone.

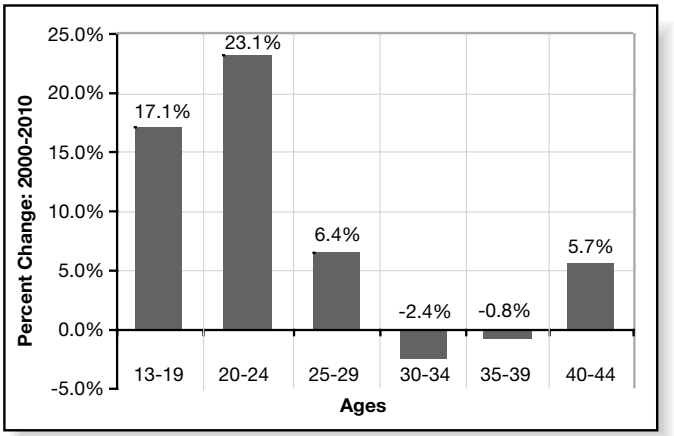
These results do not include populations whose needs for family planning may have been met though Medi-Cal or other sources, such as private health insurance. Between 1999 and 2003 the overall estimated number of women in need of publicly-funded family planning services ranged from 1.54 million to 1.69 million. The increase in the number of clients served by Family PACT, described below, demonstrates dramatic progress in meeting California's need for publicly-funded family planning services.

The Population of Women in the Reproductive Aged of 13-44 Years

Between 2000 and 2010, a shift in the population composition of reproductive aged women 13-44 is projected to result in a 3.7 percent rise in females aged 13-24 and a 3.1 percent decrease among women aged 25-44. These numbers indicate that more women with more years of childbearing ahead of them will be in the California population by the end of the decade.

The percent change between 2000 and 2010 is most notable among women aged 20-24 (23.1 percent) and female adolescent aged 13-19 (17.1 percent; see Figure 5.5.1).

Figure 5.5.1:
Percent Change in the Population of Reproductive Aged Women 13-44, by Age Group, 2000-2010



Source: California Department of Finance Population Projections.

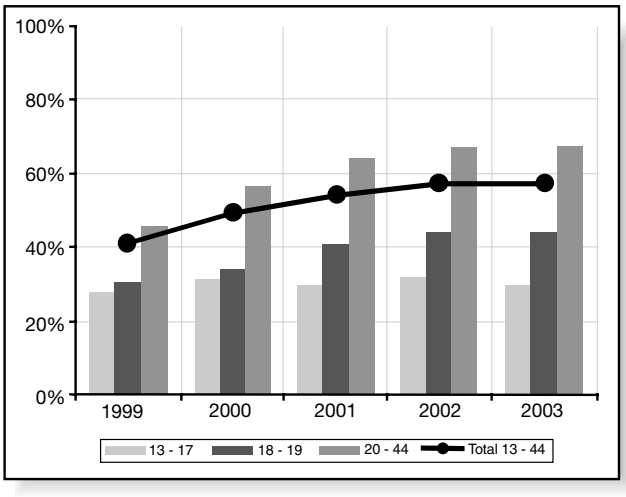
Met Need: Adolescents vs. Adults

The methodology used to estimate women in need of publicly-funded family planning services has evolved since 1997. UCSF used several data sources to derive the most accurate estimates possible of met need.[50] The following describes the proportion of need met by the Family PACT Program, stratified by age group. UCSF prepares an annual report with additional information on met need stratified by race/ethnicity.

Overall, there was a steady increase in met need for all women aged 13-44 between 1999 and 2003; during that period, met need increased from 41.1 percent to 57.3 percent. Among adolescents aged 13-19, met need increased from 29.5 percent in 1999 to 36.6 percent in 2003.

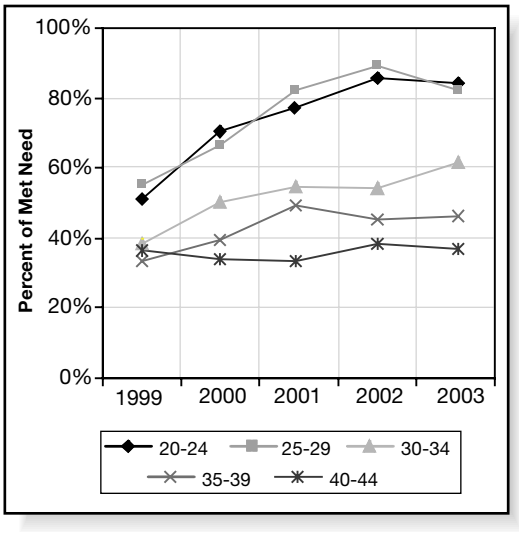
Forty-five percent of adolescent females aged 18 and 19 had their family planning needs met by Family PACT in 2003, but for younger adolescents (aged 13-17) in need of family planning services, fewer than one-third were served by the program.[51] More improvement was seen in women aged 20-44, with met need improving from 45.8 percent at the start of the period to 68 percent at the end. The largest growth occurred among women in the 20-24 age group, with met need rising from 51.4 percent in 1999 to 84.1 percent (more than eight out of 10 women) in 2003. Only the proportion of women in the 18-19 age group demonstrates a steady linear upward trend in met need throughout the five-year period; the other age groups have shown some variation over the years (see Figures 5.5.2 and 5.5.3).

Figure 5.5.2:
Percentage of Need for Publicly-Funded Family Planning Services Met by Family PACT: Females by Age



Sources: Annual Social and Economic Supplement Files to the Current Population Survey, 2000-2004; Department of Finance projected population counts, 1999-2003; California Health Interview Survey, 2001 & 2003; California Women's Health Survey, 1999-2003; and Family PACT claims data, 1999-2003.

Figure 5.5.3:
Percentage of Need for Publicly-Funded Family Planning Services Met by Family PACT: Females Aged 20-44



Sources: Annual Social and Economic Supplement Files to the Current Population Survey, 2000-2004; Department of Finance projected population counts, 1999-2003; California Health Interview Survey, 2001 & 2003; California Women's Health Survey, 1999-2003; and Family PACT claims data, 1999-2003.

50 See Appendix V for more detailed information about the met need methodology.
51 All adolescents aged 17 and under who are California residents are eligible for Family PACT, regardless of income.

Summary

Outcomes of unintended pregnancy can include detrimental and long-term health, economic, and social issues for both mothers and their children. Providing necessary and appropriate reproductive health services that permit women to truly plan their families can prevent the negative impacts of unplanned pregnancy and fertility. Family PACT has increasingly met the need for publicly-funded family planning services among both adolescent and adult populations in California. The substantial increase in the number of providers participating in the program enabled the state to offer family planning services in locations that are geographically close to clients in need and allowed clients a greater choice of providers. This growth, coupled with efforts to increase public awareness about Family PACT, led to strong gains in both clients served and need met.

However, California's rapid population growth, particularly among the adolescent population, is resulting in increasing numbers of women in need of publicly-funded family planning services. Many potential Family PACT clients and providers remain hard-to-reach or located in underserved areas. Effective recruitment efforts for these groups represent an ongoing challenge that the Family PACT Program must continually strive to meet.

Section 5.6: *Quality Improvement Activities and Work Products*

Key Findings:

- Quality assurance and quality improvement have been the keystones of service delivery in the Family PACT Program.
- The Family PACT Clinical Practice Committee (CPC) has offered evidence-based clinical opinion and recommendations for program benefits and standards.
- The Quality Improvement/Utilization Management Team initiated an innovative Provider Profile project.
- The Family PACT Provider Support Network, a collaboration of contract agencies, has offered ongoing activities to engage and educate providers.

The Family PACT Program Standards have served as the keystone for quality assurance and best practices for delivery of clinical services. The program has guided providers in the delivery of high quality family planning reproductive health services through a variety of means including provider support activities, evidence-based medicine, expert clinical advisors, and nationally recognized practice guidelines. UCSF involvement in these processes is described in this section.

Clinical Practice Committee (CPC)

The Family PACT CPC was established in 1998 to provide clinical opinion and evidence-based recommendations to DHS-OFP regarding clinical practice, the scope of program services, formulary content, program standards, policy and guideline development. The CPC has also reviewed program data and suggests quality improvement activities. Members are experts in the field of family planning and include physicians, nurse practitioners, and pharmacists with clinical expertise related to the Family PACT Program. They represent the diversity of the provider network and the geography of the state (For the member list, see Appendix IV). Since the implementation of the CMS Demonstration Project Waiver, the CPC has met 10 times. Experts on particular topics attend meetings as required. Responsibility for the facilitation of CPC falls under the UCSF SOW.

In addition, the CPC has made the following scope of service and drug formulary recommendations that have been implemented by the program:

- Addition of a drug to treat the strain of GC present in California that is resistant to the quinolone family of antibiotics;
- Addition of colposcopic procedures in accordance with the nationally-recognized American Society for Colposcopy and Cervical Pathology diagnostic and treatment guidelines;
- Removing laboratory tests which are obsolete or nonessential for family planning from the list of Family PACT benefits, such as hepatitis B screening serologies and infertility evaluation hormone tests; and
- Addition of new contraceptive technology, including the transdermal patch, vaginal ring, and hormonal intrauterine contraception.

Clinical Practice Alerts (CPA) are documents produced with CPC input on an as-needed basis, supplementing the Program Standards with recommended guidelines for the delivery of services on a focused topic. The CPAs are distributed to providers with a program letter introducing the key issue and placing the policy in the context of the standards. For example, one CPA explained minimum service delivery requirements for emergency contraception services, including advance provision. Another instructed providers to follow CDC CT screening guidelines for sexually active women aged 25 and younger, and included treatment guidelines for recommended pharmaceuticals, dosages and alternative regimens. The CPC also provided input on an Alert recommending that providers implement ACS cervical cancer screening guidelines as part of Family PACT services. This Alert was scheduled to be distributed to all providers in early 2005.

The CPC also works closely with the QI/UM Team to develop strategies that offer providers evidence-based advice on clinical practices, and to drive best practices for quality improvement. One example of this feedback loop is the CT program policy and quality improvement effort that has aimed to increase screening rates among sexually active women aged 25 and younger and appropriately decrease screening of older clients.

Quality Improvement/Utilization Management (QI/UM) Team

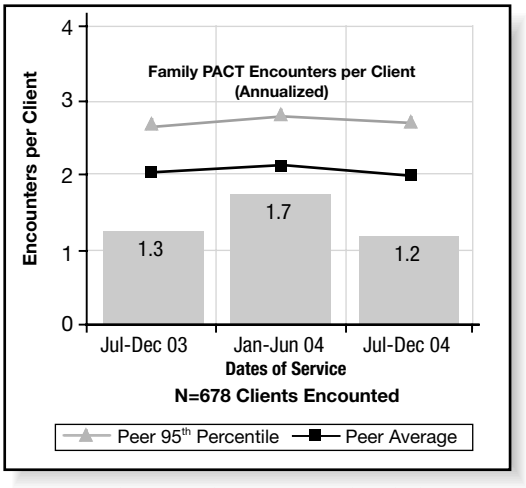
The QI/UM Team's mission has been to facilitate the implementation of sustainable, high-quality service provision by focusing on administrative practices and service utilization as discerned through claims, provider, and client enrollment data. The QI/UM Team is composed of DHS-OFP and UCSF staff and works collaboratively with the CPC and the Family PACT Provider Support Network (FPPSN) to identify quality improvement and utilization management issues, and to make recommendations for provider education, performance, and training interventions. Key activities are summarized below.

CT Screening Rates: In an effort to improve the delivery of quality services, the QI/UM Team, in collaboration with the CPC, DHS-OFP, and DHS-STD, launched a provider education and feedback project focusing on CT screening rates (details on STI testing are provided in Section 5.2 of this report). During 2003, quality improvement activities were initiated to improve provider adherence to CDC screening guidelines for CT which recommend targeting testing for this infection among sexually active women aged 25 and younger. A DHS-OFP program letter, Clinical Practice Alert, and STD Prevention Training Center professional education resources pertaining to CT were mailed to all Family PACT providers in June 2003. In September 2003, personalized letters were sent to 879 providers reporting their CT screening rates for females aged 25 years and younger with specific feedback about performance at three levels: less than 50 percent screening, 50-79 percent screening, and screening of 80 percent or more. Providers were given the option to call DHS-OFP for clarification and follow-up.

Although five percent of the original sample actually called the DHS-OFP regarding the letters, DHS-OFP took note of where the claims data may have underestimated the true screening rate and will be working with Title X[52] family planning partners to conduct chart audits in selected clinics to validate the estimates. The screening coverage estimates will now be monitored on regular intervals along with other program quality indicators to evaluate the potential impact that these data reports may have on provider behavior. The data monitoring has been a collaborative effort among DHS-OFP, UCSF, and DHS-STD.

Provider Profile Project: The QI/UM Team administers the Provider Profile Project to offer feedback to providers about their performance in comparison to peers and relative to the program as a whole. The focus of the project, launched in summer 2005, has been to design a reporting system based on quality indicators and service utilization as reflected in the administrative claims data. Initially, six indicators for the profile were identified: encounters per client (annualized), program reimbursement per client, pregnancy tests per 100 encounters, percent of use of E&M visits coded 99214, CT testing rates for women aged 25 and younger, and rate of SSN collection (see Figure 5.6.1 for an example). Each report covers six months of service delivery and will be issued semi-annually in July and January.

Figure 5.6.1:
Actual Provider Profile of Family PACT Encounters per Client



Source: Family PACT Administrative and Paid Claims Data

52 Title X grants federal funds to local healthcare agencies for family planning outreach and education, as well as clinical services to low-income clients above 200 percent FPL. All Title X providers in California are also Family PACT providers.

UCSF staff members, including a medical consultant, clinician, analyst, and several statisticians, have played integral roles in the development and facilitation of this innovative provider support activity. UCSF assumed the lead role in the project plan, which is maintained electronically. The Team also prepared the various provider letters, methodologies, and interpretation documents, as well as the provider response form. The Team also established mechanisms to respond to provider inquires. Frequently Asked Questions (FAQs) were posted on the Family PACT website and a provider telephone line was arranged for phone inquiries. An email address was also dedicated to handle provider responses.

DHS-OFP and UCSF have used the Provider Profiles in ongoing monitoring of the Family PACT Program. The presentation of the Provider Profiles project is for informational purposes. As the program continues to deliver this important quality improvement/utilization management project, DHS-OFP should continue to look for opportunities to offer focused technical assistance, support in developing individual, provider-specific QI/UM action plans, and when practice patterns reflect significant outliers in relation to peer groups, to make referrals for review by the Department's Audit and Investigation Branch. Outliers are identified through data collected and plotted by UCSF statisticians.

FPPSN

The FPPSN has been composed of contract agencies responsible for establishing and conducting Family PACT provider support activities including professional education, training, and technical assistance, as well as provider recruitment, orientation, and practice integration. The FPPSN has worked under the direction of DHS-OFP to carry out quality improvement strategies identified by the CPC and the QI/UM Team, and the monitoring of administrative claims data. Agencies that have participated in the FPPSN include:

- California Family Health Council
- California STD/HIV Prevention Training Center
- Center for Health Training
- Electronic Data Systems
- UCSF, Bixby Center for Reproductive Health, Research & Policy

Professional education, consultation, and training topics have been identified by the FPPSN to enhance the integration of new technology into family planning and reproductive health services, to improve the adherence to standards, and to achieve the Family PACT Waiver Demonstration Project goals and objectives. Specific topics have included CT screening for women aged 25 and younger, new contraceptive technology such as contraceptive patches, rings and implants, and reproductive health services with a special focus on adolescents and males.

Summary

Cultivating better care and support services in the Family PACT Program has involved the dedicated and coordinated efforts of clinicians, allied health professionals and paraprofessionals, administrative staff, and external agencies. Rapidly changing technologies, client preferences, reporting requirements, and training mechanisms have presented both challenges and opportunities to the collaborations established by Family PACT to best serve a growing client base. This chapter has illustrated the program's ongoing commitment to evidence-based quality improvement and the means by which it can be achieved. Through continued refinement in program services and delivery, provider accountability, and improved program outcomes can be assured.

Section 5.7: *Cost-Benefit Analyses*

Key Findings:

- In 2002, Family PACT dispensed contraceptives to nearly one million women, averting 205,000 unintended pregnancies.
- These pregnancies would have cost the public $1.1 billion up to two years and $2.2 billion up to five years after birth. Each dollar invested in Family PACT services in 2002 saved the public sector $2.76 over two years and $5.33 over five years.
- Male CT testing and treatment services through Family PACT have saved approximately $7.1-10 million in medical costs annually.

Pregnancies Averted

Provision of contraceptive services through Family PACT has enabled many clients to avoid unintended pregnancies. Data from the UCSF Cost-Benefit Analysis detailed below show that, in 2002, Family PACT dispensed contraceptives to 926,218 women, averting an estimated 205,000 pregnancies. Of these, 79 percent would have occurred among adults (aged 20-44) and 21 percent among adolescents (aged 15-19). These pregnancies would have resulted in approximately 94,000 births, 78,600 abortions, 30,300 miscarriages, and 2,100 ectopic pregnancies (See Figure 5.7.1).

Cost-Benefit Analysis of Preventing Unintended Pregnancy

The Family PACT Cost-Benefit Analysis compared the program's annual expenditures to the public sector costs that would have been incurred by a woman and child up to two and five years following a birth. The results predict the government savings from investing in Family PACT. The methodology for this analysis is provided in Appendix VI.

Total expenditures for Family PACT clinical services in 2002 were $403.8 million. Each pregnancy averted by Family PACT during this time saved the public sector an average of $5,431 in medical, welfare, and social service costs for a woman and child over two years ($4,675 for adults and $8,228 for adolescents) and $10,508 over five years ($9,338 for adults and $14,838 for adolescents). The total cost-savings of preventing unintended pregnancies through Family PACT was more than $1.1 billion over two years ($754 million among adults and $359 million among adolescents) and $2.2 billion over five years ($1.5 billion among adults and $647 million among adolescents) (see Figure 5.7.2).

Figure 5.7.1:
Contraceptive Dispensing and Pregnancies Averted through Family PACT in 2002

	Number of Family PACT clients dispensed contraception	Average months of contraceptive protection dispensed	Estimated pregnancies averted *	Estimated induced abortions averted	Estimated births averted
Total females	926,218	6.91	205,000	78,600	94,000
Adolescents	202,289	6.37	43,600	15,700	21,400
Adults	723,929	7.06	161,300	62,900	72,600

* Spontaneous abortions and ectopic pregnancies not shown. Columns may not add due to rounding.

Source: Family PACT Cost-Benefit Analysis, 2004.

Figure 5.7.2:
Costs Saved by Population and Program Characteristics, 2002

	Conception to age two		Conception to age five	
Age				
Adolescents (ages 15-19)	$358,921,000	32%	$647,247,000	30%
Adults (ages 20-44)	$754,378,000	68%	$1,506,894,000	70%
Service Type				
Pregnancy-related medical care	$328,887,000	29%	$328,887,000	15%
Other medical care	$231,523,000	21%	$432,169,000	20%
Income support	$342,952,000	31%	$489,908,000	23%
Social services	$188,760,000	17%	$852,491,000	40%
Children with special needs	$21,178,000	2%	$50,686,000	2%
Payer				
Federal	$689,751,000	62%	$1,404,315,000	65%
State	$412,780,000	37%	$739,594,000	34%
Local	$10,768,000	1%	$10,232,000	1%
Total costs saved	$1,113,299,000	100%	$2,154,141,000	100%

Source: Family PACT Cost-Benefit Analysis, 2004.

Among the costs that would have been incurred from conception to age two, pregnancy-related medical care and income support made up the largest portion (29 percent and 31 percent, respectively). To age five, social services, such as subsidized child care or preschool, made up the largest portion of the savings (40 percent). Considering the funding sources of each program, the share of the cost savings to age two was 62 percent federal, 37 percent state, and 1 percent local, resulting in total savings of $690 million, $413 million, and $11 million, respectively. To age five, the share of cost savings was 65 percent federal, 34 percent state, and 1 percent local, for respective total savings of $1.4 billion, $740 million, and $10 million.

Given the high public sector costs of unintended pregnancy, preventing pregnancy through Family PACT has been extremely cost-effective. In 2002, every dollar spent on Family PACT saved the public sector $2.76 in public heath and welfare expenditures over two years, and $5.33 over five years (see Figure 5.7.3).

Figure 5.7.3:
Cost-Effectiveness of the Family PACT Program, 2002

Pregnancies averted to female clients	205,000
Average public cost per pregnancy	
To age two	$5,431
To age five	$10,508
Cost savings from averting pregnancies	
To age two	$1,113,299,000
To age five	$2,154,141,000
Cost of Family PACT services	$403,834,000
Cost-benefit ratio	
To age two	$2.76
To age five	$5.33

Source: Family PACT Cost-Benefit Analysis, 2004..

Cost-Effectiveness of CT Testing

In FY 2001-02, a cost-effectiveness analysis was undertaken by UCSF to assess whether the expansion of diagnostic CT testing and treatment services to males in the Family PACT Program has been cost-effective. The study followed a population of 10,000 males similar to those enrolled in Family PACT and their female partners through two years of CT exposure and treatment possibilities. The main outcomes tracked in this model were the costs of providing CT testing and treatment, as well as the number of cases of CT-related sequelae, such as ectopic pregnancy and PID.

It was estimated that the annual cost of untreated CT, including the costs of complications to men and their female partners approximated $21 million. In contrast, the annual cost of testing and treating males through Family PACT[53] approximated $10.6-13.5 million, significantly less than it would have been in the absence of the Family PACT Program. It is thus estimated that in 2002, Family PACT's male CT testing and treatment services saved approximately $7.1-10 million in public and private medical costs, prevented approximately 6,000 cases of PID, and reduced the number of CT cases by 8,500. The expansion of diagnostic testing and treatment services for CT to males in the Family PACT Program has further increased the program's cost-effectiveness.

Summary

The trade-off between proactively investing in family planning services and reactively incurring long-term medical and social costs due to unintended pregnancies and sexually transmitted infections heavily favors the former approach from an economic perspective. UCSF cost-benefit analyses have demonstrated that Family PACT services saved more than $5,400 for each averted pregnancy. Providing CT testing to males alone saved more than $7 million and reduced Family PACT client cases of this infection by more than 8,000.

53 The cost of CT includes testing, treatment, and partner management services, as well as the costs of untreated CT in male clients and their female partners.

Section 6.1: *Recommendations and Next Steps*

Findings from this report demonstrate that the Family PACT Program has successfully made family planning services widely available to low-income women and men in California. The impact of the program is evident in its prevention of unintended pregnancies, STIs, and cases of cervical cancer. The program's first years have set the foundation to further its expansion, enhance quality improvement activities, and to increase the efficiency of intervention strategies. However, there are a number of areas that can be improved in order to expand the reach of Family PACT and achieve a greater impact on program goals. UCSF recommends the development or enhancement of strategies to:

1. **Increase the number of clients served by Family PACT, particularly among target population subgroups such as males, adolescents, women living in areas of high unmet need for family planning services, and specific racial/ethnic groups.**
2. **Retain and increase the number of providers rendering Family PACT services.**
3. **Increase referrals to primary care services for Family PACT clients.**
4. **Monitor and improve the quality and integrity of Family PACT services.**
5. **Monitor and improve the quality of Family PACT administrative data.**

UCSF's evaluation of the Family PACT Program generated many specific action steps and strategies for meeting these general recommendations. The grid below is intended to serve as a foundation for DHS-OFP's priority setting and to inform the development of future work plans. Each of the five general recommendations is followed by specific action steps and potential strategies to consider. The last column in the grid refers to the general waiver or program goal[54] or objective that these strategies address. While each strategy cannot always be separated neatly from the others (e.g., efforts to improve the quality of services will affect client enrollment), specific action steps are listed below under one individual area of improvement.[55]

54 Goals of the waiver and the program are briefly described in Section 1.2. The following abbreviations are used in the grid:
ATC (Access to Care): related to general access to reproductive health services for all clients;
PC (Primary Care): related to the fourth goal of the 1115 Medicaid Waiver 2004 renewal application;
PI (Program Integrity): related to program administration, provider support functions, or evaluation and monitoring;
QI (Quality Improvement): related to quality of clinical services or adherence to program standards;
TP (Target Populations): related to the 1115 Medicaid Waiver target populations.

55 For a comprehensive list of recommendations for best practices, see the Issues Assessment, which describes problems identified by the evaluation and provides recommendations on how to resolve them. It is continuously updated as new issues emerge and are resolved to help inform DHS-OFP of the program's progress in reaching its goals.

Recommendation #1: Increase the number of clients served by Family PACT, particularly among target population subgroups such as males, adolescents, women living in areas of high unmet need for family planning services, and specific racial/ethnic groups.

Action Steps	Potential Strategies	Goal
Develop strategies to increase the number of clients using Family PACT services, particularly among target population subgroups.	1. Foster innovative client outreach, such as: • Targeted media campaigns, • Website enhancements, • Continued funding for direct outreach to adolescent clients through the TeenSMART Outreach program, • Expanded funding for direct outreach to other target populations.	ATC
	2. Disseminate best practices for successful client outreach.	ATC
	3. Develop a study to explore the reasons why clients stop using Family PACT services.	ATC
	4. Support provider efforts to: • Make services more male-friendly, teen-friendly, and culturally competent, • Encourage clients to bring partners in for services, • Inform female clients of the availability of non-invasive STI tests for their male partners, • Employ STI partner management techniques, • Ensure that clinical sites and services are accessible to people with disabilities and compliant with federal disability law.	ATC, TP
	5. Encourage providers to engage in activities that clients perceive as creating accessibility, such as informing clients of wait times and offering drop-in appointments.	ATC
	6. Review all program materials produced in multiple languages annually for accuracy and appropriateness in translation, content, and literacy level.	ATC
Analyze expected demographic changes and monitor unmet need for publicly funded reproductive health care and trends over time.	1. Quantify the impact of demographic changes in the population of fertile young women on the need for publicly funded family planning services and monitor this need by race/ethnicity, age, parity, and county/geographic area. Use this information to inform outreach strategies targeted to specific groups of Californians in need.	ATC, PI
	2. Develop and implement a Family PACT unmet need survey to collect state-specific data on reproductive health needs not available through existing survey and population data sets, as funding allows.	ATC, PI

Recommendation #1: Increase the number of clients served by Family PACT, particularly among target population subgroups such as males, adolescents, women living in areas of high unmet need for family planning services, and specific racial/ethnic groups.

Action Steps	Potential Strategies	Goal
Continuously update the automated Family PACTInformation and Referral Line.	1. Continuously encourage providers to maintain their Medi-Cal Master File contact information with current information.	ATC
	2. Institute ongoing, periodic data uploads to update the provider contact information on the Information and Referral Line.	ATC, PI
	3. Maintain updated contraceptive, STI, and other information for clients in appropriate languages.	ATC, QI
Renew funding for a statewide media campaign to increase awareness about Family PACT	1. Renew funding for media outreach campaigns.	ATC, TP
	2. Utilize targeted media messages to raise awareness among underserved and rural communities, waiver target populations, and organizations serving Family PACT-eligible populations.	ATC, TP
	3. Develop data systems and an evaluation plan to measure the impact of the campaign on client enrollment and public awareness.	PI
Promote collaboration between Family PACT providers and other programs and organizations, including the state's TPP programs, serving Family PACT-eligible populations.	1. Continue to require that Teen Pregnancy Prevention (TPP) programs develop formal collaborative partnerships and referral mechanisms with Family PACT providers.	TP
	2. Sustain TPP staff awareness of Family PACT eligibility criteria through regular training and mailings to TPP program coordinators.	TP
	3. Educate providers on the benefits of increasing their client base, particularly among males and adolescents, and on how to partner with TPP and other programs and community-based organizations (CBOs) serving low-income populations.	ATC, PI TP
	4. Incorporate information about collaboration with organizations and programs that serve potential Family PACT clients into the existing provider orientation trainings and ongoing regional provider forums.	ATC, PI TP
	5. Invite Family PACT providers and other programs to joint conferences and regional meetings to share ideas and discuss collaborative opportunities. Consider including other state programs such as the California School Aged Families Education program (Cal-Safe) and the Cal-Learn program.	PI, TP
	6. Direct TPP and other programs and organizations to the Family PACT website for an updated list of Family PACT providers and information about eligibility, benefits, and policies for adolescents and males.	ATC, TP
	7. Identify and address barriers to collaboration faced by CBOs to facilitate future partnerships with Family PACT providers.	ATC, TP
	8. Develop and disseminate best practice outreach models after documenting innovative referral strategies used by CBOs.	ATC

Recommendation #2: Retain and increase the number of providers rendering Family PACT services.		
Action Steps	**Potential Strategies**	**Goal**
Conduct outreach to eligible providers not currently rendering Family PACT services.	1. Recruit Medi-Cal providers who are not enrolled in Family PACT, but serve a high volume of clients within populations of interest (e.g., African Americans, adolescents, males, etc.).	TP
	2. Recruit Medi-Cal providers who are not enrolled in Family PACT, but who practice a clinical specialty most likely to offer family planning services.	ATC
	3. Work with Medi-Cal Provider Enrollment to update outdated specialty information on provider records to facilitate identifying prospective providers over time.	PI
	4. Evaluate the effectiveness of provider outreach strategies in increasing the pool of enrolled and rendering Family PACT providers.	ATC, PI
Encourage enrolled Family PACT providers to remain active in the program.	1. Investigate and address reasons why providers voluntarily leave the program.	ATC, PI
	2. Investigate and address why some providers enroll, but do not serve clients in the program.	ATC, PI
	3. Develop a system of mentoring by seasoned providers to assist providers new to the program.	PI
Improve the Family PACT provider application and billing process so that it is easier for providers to enroll in the program and bill for services.	1. Streamline the current provider application, enrollment, orientation, and billing process.	PI
	2. Create a web-based application to allow providers to submit and check the status of their application on line.	PI
	3. Modify the provider enrollment form to collect information on the availability of services for individuals with disabilities.	ATC, PI
	4. Work with contractor to decrease call wait times on the provider assistance hotline and provide input into hotline operator training so that questions are answered quickly and effectively, and the hotline is “customer friendly”.	PI
	5. Modify the billing system for providers to more closely match Medi-Cal rules and facilitate electronic claims.	PI
	6. Improve the claims processing system to reduce the frequency of payment errors that result from insufficient or incorrect edits.	PI
Continuously update the Family PACT website to include practical information for potential and current providers.	1. Post continuously updated, expanded, and easy to use information on the Family PACT website.	ATC, PI
	2. Develop an internet-based provider orientation module to expedite the enrollment process for rural providers and others unable to travel to attend face-to-face sessions.	ATC, PI

Recommendation #2: Retain and increase the number of providers rendering Family PACT services.		
Action Steps	**Potential Strategies**	**Goal**
Provide opportunities for continuing education units (CEUs) and professional development.	1. Investigate opportunities to offer CEUs to providers attending Family PACT provider forums.	PI
	2. Offer opportunities for CEUs and professional development through teleconferences and web-based training modules.	PI
Increase efforts to remove fraudulent or abusive providers while retaining access to services for Family PACT clients.	1. Develop data mining and surveillance activities to detect fraudulent providers.	PI
	2. Invest in human resources to investigate non-compliant providers.	PI
	3. Investigate the extent to which provider disenrollment affects client access.	ATC, PI
Recommendation #3: Increase referrals to primary care services for Family PACT clients.		
Action Steps	**Potential Strategies**	**Goal**
Encourage Family PACT providers to screen clients with primary care needs for eligibility for other insurance programs.	1. Develop a fact sheet to help providers determine the appropriate funding stream for their clients and to facilitate referrals to other insurance programs, such as Healthy Families, Medi-Cal, and AIM.	PC
	2. Incorporate information about recommended screening practices, eligibility requirements and enrollment for public primary care programs into: • Provider orientation sessions, • Regional provider forums, • Program letters.	PI, PC
Encourage Family PACT providers to use standardized referral practices when referring clients to primary care services and other insurance programs.	1. Develop and encourage standardized referral practices, such as: • Standardized referral forms and protocols, • Appropriate client follow-up.	PC
	2. Incorporate information on effective referral practices into existing provider orientation trainings and ongoing regional provider forums, with particular attention to providers with the greatest need for referral resources and information.	PC
	3. Develop and distribute referral resources to Family PACT providers, in print and on the website, such as: • Lists of local insurance offices and low- or no-cost referral opportunities, • Resource books, • List of websites for community primary care services.	PC
	4. Facilitate partnerships with local primary care providers and organizations.	PI, PC
	5. Investigate the specific types of primary care services that clients require and receive outside of Family PACT. Investigate how these services interact with Family PACT services to identify opportunities for synergies with primary care providers.	PC

Recommendation #4: Monitor and improve the quality and integrity of Family PACT services.		
Action Steps	**Potential Strategies**	**Goal**
Continue to support quality improvement activities.	1. Continue to look for opportunities to offer technical assistance to providers, support development of QI/UM action plans, and make referrals for review to the DHS Audits and Investigations Branch, when appropriate.	PI, QI
	2. Collaborate with experts, both clinical and educational, to deliver best practices and other evidence-based information to Family PACT providers.	QI
	3. Cultivate the Family PACT Provider Support Network to maximize opportunities for innovative provider support activities.	PI
Improve provider adherence to Family PACT Program Standards.	1. Develop indicators for Family PACT Standards using clear benchmarks to measure adherence and incorporate findings into provider-specific reports and performance assessment tools.	QI
	2. Develop a clear definition of cultural and linguistic competence in the context of the Family PACT Program. Include experts, stakeholders, and the Clinical Practice Committee in developing a definition.	QI
	3. Continuously update Family PACT Standards in order to meet current guidelines and recommendations set forth by federal and state governments and professional organizations.	QI
	4. Develop updated screening recommendations based on STI prevalence rates and risk factors of Family PACT clients to address inappropriate levels of screening coverage in the program.	QI
	5. Offer follow-up training to providers to inform them about best STI testing practices.	PI, QI
Evaluate provider education and support services, including orientation sessions and provider forums.	1. Transmit data on a consistent basis from provider education and support activities to evaluators.	PI
	2. Improve data gathering and transfer systems to aid in the assessment and improvement of provider education efforts.	PI
Promote the completion of a comprehensive, standardized health history for each client, including a contraceptive history and sexual risk assessment.	1. Create a standardized medical and contraceptive history and sexual risk assessment tool for providers.	QI
	2. Inform providers about the new, standardized forms through a Clinical Practice Alert, audio conferences, and provider forums, and post forms on the Family PACT website.	PI, QI
	3. Initiate a study on the discrepancies in the sexual and STI histories taken by provider type, in order to inform planning for targeted provider assistance.	PI

Recommendation #4: Monitor and improve the quality and integrity of Family PACT services.		
Action Steps	**Potential Strategies**	**Goal**
Promote continuous use of birth control methods and explore disparities in contraceptive dispensing.	1. Identify and address the reasons for method switching and possible problems with method continuation among clients.	QI
	2. Investigate how contraceptive method dispensing varies by racial/ethnic group in order to develop targeted interventions using quantitative and qualitative analysis methodologies.	ATC, QI
Encourage the use of EC and increase adherence to the program's advance EC provision policy.	1. Implement strategies to increase providers' overall knowledge of emergency contraception (EC) and of the program's advance EC provision policy, especially among private providers.	PI, QI
	2. Investigate factors that influence EC provision and variation by provider type, geographic area, client age and race/ethnicity.	ATC, QI
	3. Address the topic of EC with providers through methods such as Clinical Practice Alerts, audio conferences, and provider forums.	PI, QI
	4. Include EC provision on the client intake form to remind providers to ask clients whether they want EC in advance of need.	PI
Encourage the use of cost-effective, long-term birth control methods.	1. Increase providers' general knowledge about cost-effective, long-term methods, such as IUC and sterilization, through Clinical Practice Alerts, audio conferences, and provider forums.	QI
	2. Assess the extent to which billing problems and low reimbursement play a role in low provision rates for these methods and implement provider support activities to address relevant issues.	PI
	3. Examine the cost-effectiveness of new birth control technologies.	PI
Encourage the provision of barrier methods to prevent sexually transmitted infections (STIs) as well as unintended pregnancies.	1. Explore and address the reasons that barrier method dispensing to males has decreased in recent years.	PI, QI
	2. Assist providers in educating clients about the importance of using barrier methods to prevent STIs.	PI, QI
	3. Develop outreach strategies to increase male testing for CT to improve health outcomes and cost savings.	ATC

Recommendation #4: Monitor and improve the quality and integrity of Family PACT services.		
Action Steps	**Potential Strategies**	**Goal**
Promote the appropriate management and reporting of STIs and explore racial/ethnic differences in STI testing rates.	1. Implement strategies to promote compliance with STI treatment guidelines among Family PACT providers and increase the proportion of clients receiving appropriate follow-up care.	QI
	2. Educate providers on effective methods for enhancing STI screening rates, such as: • Give clients reminder cards when re-screening is indicated, • Schedule follow-up testing when the initial diagnosis is made to facilitate re-testing.	QI
	3. Encourage providers to develop partnerships with local public health departments to enhance STI treatment follow-up among cases and their partners.	PI, QI
	4. Investigate why required reporting of CT is relatively low, and why STI testing rates vary by racial/ethnic group, in order to develop appropriate interventions with providers.	PI, QI
	5. Identify and initiate strategies to facilitate provider reporting of STIs until the DHS web-based CMR communicable disease system is implemented.	PI, QI
Promote improved compliance with program standards for CT among Family PACT providers.	1. Encourage providers to collect a baseline CT test for women aged 25 years and younger and thereafter at appropriate intervals.	QI
	2. Address the low level of testing among young women and the unnecessarily high level of testing among older women with continuing quality improvement efforts.	QI
	3. Inform providers of appropriate CT testing standards in a Clinical Practice Alert, provider orientation sessions, forums, and updates.	PI, QI
Increase provider awareness of evidence-supported cervical cancer screening guidelines and encourage adherence through application of appropriate interventions.	1. Use targeted approaches to increase appropriate testing utilization and decrease disparities in cervical cancer screening rates among different racial/ethnic groups.	QI
	2. Develop a monitoring system for women with abnormal Pap smears in order to follow their case management to improve care.	PI, QI
	3. Determine the extent to which Family PACT providers are informing clients about appropriate screening periodicity.	QI
	4. Provide additional provider training on this issue, with priority given to clinicians who have extremely low testing rates.	PI, QI

Recommendation #5: Monitor and improve the quality of Family PACT administrative data.		
Action Steps	**Potential Strategies**	**Goal**
Investigate the content and quality of E&C visits.	1. Monitor the trends in E&C visit length over time. 2. Investigate factors influencing trends in the length of E&C visits, such as disenrolled provider billing patterns or changes in the needs of clients.	PI, QI
Increase the number of Family PACT clients obtaining preconception and interconception care.	1. Assist clients and providers in becoming better informed about the importance of preconception and interconception care for clients capable of becoming pregnant. 2. Encourage providers to discuss desired family size and birth timing with clients and to encourage clients to return to a Family PACT provider after giving birth.	PC ATC, PC
Revise the CEC form, monitor its accuracy and comprehensiveness, and encourage providers to complete it.	1. Improve the accuracy of Family PACT administrative data by modifying the CEC form. The CEC form should: • Record why the client does not have or cannot provide a SSN, • Include Mandarin and Russian as primary language choices, • Be printed in additional languages, • Make it easier for providers to indicate if a client is insured, but using Family PACT services because of specific confidentiality concerns, • Collect information necessary to facilitate billing of Medicaid Managed Care clients to the appropriate managed care plan rather than to Family PACT when indicated, • Record the needs of clients with disabilities. 2. Continue efforts to educate and motivate providers to: 1) request client SSNs, 2) document the reason if an SSN is not provided, and 3) update the enrollment file when it is collected after the initial eligibility determination. 3. Continue to emphasize provider responsibilities and requirements to complete CEC forms accurately. Provider orientation and update sessions should offer instructions on completing the forms. 4. Continue to provide on-site technical assistance and targeted interventions for providers with on-going issues in completing CEC forms accurately. 5. Investigate developing a pilot income and eligibility verification system that determines the accuracy of self-reported information without compromising access to care or adding excessive administrative costs relative to gain.	PI PI PI PI

Recommendation #5: Monitor and improve the quality of Family PACT administrative data.

Action Steps	Potential Strategies	Goal
Implement a series of edits to the claims data system.	1. Implement a series of system edits and a scheme to monitor the success of modifications. 2. Suggested issues that warrant modifications include: • High rates of reimbursement for a single paid claim, • Treatment Authorization Request (TAR) claims for services unrelated to Family PACT, • Double billing for Depo-Provera injections. 3. Refer to the Issues Assessment Tool for a complete and updated list of current suggested edits.	PI PI PI
Promote accurate coding of services.	1. Continue to utilize Family PACT billing data to identify providers who consistently misuse codes, bill incorrectly (e.g., for sterilization procedures), or serve a high volume of clients under one or a few PDCs. 2. Offer these providers technical assistance, monitor their billing behaviors, and if necessary, refer them to DHS Audits and Investigations Branch.	PI PI
Develop program improvement strategies in response to issues identified through the analysis of Family PACT data and monitor progress towards resolution.	1. Utilize a system, such as the Issues Assessment Tool, to ensure that program improvement issues identified through evaluation activities are addressed. 2. Develop special projects, short-term studies, or ad hoc workgroups to address issues that require further investigation, program modifications, or new interventions, directly or through subcontractors. 3. Monitor issues that have been addressed though a system such as the Issues Assessment Tool.	PI PI PI
Update all protocols for data handling and revise the program's proprietary Primary Diagnosis Codes (PDCs) to comply with HIPAA requirements.	1. Review and update Family PACT data handling and release protocols to conform to HIPAA and state regulations, which have established stringent data handling requirements for all activities that may risk client privacy. 2. Revise the PDC coding scheme to comply with HIPAA regulation and develop a PDC mapping plan to minimize the loss of trend analysis capability when the PDC code revision occurs. 3. Promote the transition to HIPAA-compliant code sets so that large providers such as the University of California and others with HIPAA compliant billing systems can enroll in Family PACT and use their existing billing systems. 4. Review PDCs periodically for accuracy and usefulness as new services and supplies are added or removed from program benefits.	PI PI PI PI

Section 6.2: *Conclusion*

The terms and conditions of California's Section 1115 Family Planning Waiver required the involvement of an independent evaluator that would be responsible for measuring the program impact through methodologically sound evaluations. As outlined in this report, the collaboration of DHS-OFP and UCSF satisfied these terms through the development and implementation of a comprehensive evaluation strategy. A mixed method evaluation approach that included quantitative and qualitative analyses, as well as regular monitoring of claims data, allowed UCSF researchers to assess the perspective of multiple stakeholders and to validate findings. The UCSF evaluation team developed mechanisms to ensure program and financial accountability, such as the provider profile project and regular review and follow-up of claims data. Special studies, such as the TAS and CEI, provided important information about the process of program implementation. The MRRs measured adherence to clinical standards and suggested corrective actions. Finally, the ability to demonstrate Family PACT's significant cost savings through cost-benefit analyses has been crucial in times of fiscal constraint that emphasize the cost-benefit ratio of public health programs.

The needs of the Family PACT evaluation will change as the program matures from one that is concentrated on expanding the provider network and increasing client utilization towards one with an increased focus on program integrity and quality as well as the ability to generate longitudinal and comparative data. Evaluation efforts will seek to measure whether Family PACT successfully reaches women and men who are most in need of services but are difficult to reach. Indicators for aspects of care that are challenging to measure, such as cultural competence and patient-centered counseling, will require creative assessment techniques. Finally, dialogue with CMS has indicated the need for increased focus on linkages between health and social service programs, particularly referrals of family planning clients to primary care services.

In the next phase of the Family PACT Program, it will also be necessary to reassess various components of the evaluation framework. How will stakeholders be involved in decision-making and evaluation activities? How can the gap between evidence-based care and day-to-day practice be closed if the provider community becomes more diverse? How will findings be disseminated so that they impact program and policy decisions most effectively? The responses to these questions will require ongoing, intense collaboration and well-defined communication channels between DHS-OFP and the UCSF evaluation team. The successful use of evaluation data will enhance Family PACT's ability to provide access to cost-effective reproductive health services that meet standards of clinical care. Assuring the continuation of Family PACT's high-quality, comprehensive family planning service delivery to California's low-income populations represents an important investment in the state's future.

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